LaCare

A Program of AmeriHealth Mercy of Louisiana



Provider Manual

www.lacarelouisiana.com

Primary Care

Specialist

Ancillary

Hospital

Working Draft 2011

Table of Contents

Introduction *1*

About LaCare **2**

Who We Are **2**

Our Values **2**

Important LaCare Telephone Numbers **3**

Provider's Bill of Rights **5**

Section I Physician Office Standards & Requirements *7*

PCP Reimbursement **8**

PCP Fee-For-Service Reimbursement **8**

Member Linkage to PCP **8**

Completing Medical Forms **8**

KIDMED Program (EPSDT) **8**

Vaccines for Children Program (VFC) **9**

Louisiana Immunization Network for Kids Statewide (LINKS) **9**

Your Role as PCP **10**

Patient Centered Medical Home **11**

The PCP Office Visit **15**

Physician Coverage **15**

Access Standards for PCPs **15**

Appointment Accessibility Standards **15**

Additional Requirements of PCPs **16**

PCP Selection **18**

Referrals **18**

Forms/Materials Available **19**

Visit Reporting **19**

Completion of Encounter Data **19**

Transfer of Non-Compliant Members **21**

Requesting a Freeze or Limitation of Your Member Linkages **21**

Policy Regarding PCP to Member Ratio **21**

Confidentiality of Medical Records **21**

Letter of Medical Necessity (LOMN) 22
PCP Responsibilities Under the Patient Self Determination Act 22
Preventive Health Guidelines 23
Behavioral Health Screening 23
Clinical Practice Guidelines 23
Primary Care Provider Incentive Plan 24
Specialty Care Providers 25
The Specialist Office Visit 25
Reimbursement/Fee-for-Service Payment 25
Specialist/Sub-specialist Services 25
Specialist Access & Appointment Standards 26
Confidentiality of Medical Records 26
Letters of Medical Necessity (LOMN) 26
Specialist Responsibilities Under the Patient Self Determination Act 27
Specialist as a PCP for Special Needs Members 27
PCP & Specialist Office Standards 29
Physical Environment 29
Medical Record Requests 30
Medical Record Standards 30
Medical Record Retention Responsibilities 32
Provider Communications Materials 32
Section II Member Eligibility 33
Enrollment Process 34
LaCare Identification Card 34
Welcome Packet 35
Continuing Care 35
Verifying Eligibility 36
Monthly Panel/Linkages List 37
Change in Recipient Coverage 39
Nursing Facilities 40
LaCare Retroactive Eligibility 40
Eligibility for Institutionalized Members 40
Incarcerated Member Eligibility 41

Loss of Benefits **41**
Plan Enrollment **41**
Voluntary Enrollees **42**
Section III Covered Benefits ***43***
Covered Benefits **44**
Services Not Covered **45**
Co-Payment **46**
Section IV Referral & Authorization Requirements ***47***
Referrals **48**
Referrals Requirements **48**
Services Requiring a Referral: **48**
Services Not Requiring a Referral (Member Self Referral): **48**
Referral Process **49**
Generating electronic referrals through NaviNet **49**
Paper Referrals **50**
Approval of Additional Procedures **50**
Additional Procedures Performed in the PCP or Specialist Office or Outpatient Hospital/Facility Setting **50**
Additional Procedures Requiring Inpatient or SPU Admission **50**
Follow-Up Specialty Office Visits **51**
Out-of-Plan Referrals **51**
Standing Referrals **51**
Referrals/Second Opinions **51**
Prior Authorization Requirements **52**
Notification Required **52**
Services Requiring Prior Authorization: **52**
Policies and Procedures **54**
Medically Necessary **54**
Alerts **54**
Benefit Limits and Co-Payments **54**
Authorization and Eligibility **55**
Ambulance – Transportation **55**
Ambulance - Non emergent Transportation- (NEMT) **55**

Ambulatory Surgical Centers 56
Behavioral Health Services 56
Dental Services 57
Durable Medical Equipment 57
Covered Services 57
Elective Admissions and Elective Short Procedures 59
Emergency Admissions, Surgical Procedures and Observation Stays 59
ER Medical Care 60
Emergency Medical Services 60
Emergency SPU Services 61
Emergent Observation Stay Services 61
Medical Observation Stay 62
Emergency Inpatient Admissions 63
Emergency Services Provided by Non-Participating Providers 64
Family Planning 64
Hysterectomies 64
Sterilization 65
Abortion 65
Home Health Care 66
Hospice Care 66
Hospital Transfer Policy 67
Medical Supplies 67
Newborn Care 68
LaCare Nurse Call Line – 1-888-632-0009 69
Nursing Facility 70
Covered Services 70
Obstetrical/Gynecological Services 70
Direct Access 70
WeeCare Maternity Management 70
Obstetrician's Role In WeeCare 70
Ophthalmology Services 71
Non-Routine Eye Care Services 71
Outpatient Laboratory Services 71

Outpatient Renal Dialysis 72
Free-Standing Facilities 72
Hospital Based Outpatient Dialysis 72
Outpatient Testing 73
Outpatient Therapies 73
Physical, Occupational, and Speech 73
Pediatric Preventive Health Care Program 73
KIDMED/EPSDT Screens 73
EPSDT Covered Services 74
EPSDT Expanded Services 75
Eligibility for EPSDT Expanded Services 75
EPSDT Expanded Services Requiring Prior Authorization 75
Obtaining PCP Approval for EPSDT Expanded Services 75
EPSDT Expanded Services Approval Process 76
EPSDT Expanded Services Denial Process 76
EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions 76
Age Appropriate Evaluation and Management Codes 77
Completing the CMS 1500 or UB-04 Claim Form 77
Additional EPSDT Information 78
Newborn Screening 78
Dental Screening 81
Vision Testing 82
Hearing Screening 83
Development/Behavior Appraisal 83
Autism Screening 84
Anemia Screening 84
Sickle Cell 85
Tuberculin (TB) Test 85
Albumin and Sugar 85
Cholesterol Screening 86
Lead Level Screening 86
Gonorrhea, VDRL, Chlamydia and Pap Smear 86
Bacteriuria 86

Immunizations 86
Pharmacy Services 87
Podiatry Services 87
Podiatry Services/Orthotics 87
Preventable Serious Adverse Events Payment Policy 87
Rehabilitation 89
Vision Care 89
Vision Benefit Administrator 89
Section V Claims Disputes and Provider Complaints ***91***
LaCare Claims Filing Instructions 92
National Provider Identification Number 92
Prompt Pay Requirements 93
Claim Filing Deadlines 93
Original Claims 93
Re-submission of Rejected Claims 94
Re-submission of Denied Claims 94
Submission of Claims Involving Third Party Liability 94
Failure to Comply with Claim Filing Deadlines 94
Third Party Liability and Coordination of Benefits 94
Reimbursement for Members with Third Party Resources 95
Commercial Third Party Resources 95
Fraud & Abuse 95
Contact Information 96
Provider Complaints and Claims Disputes 96
Informal Disputes 96
Common Reasons for Claim Rejections & Denials 96
Adjusted Claims 97
Formal Provider Disputes Process 98
Examples of Complaints 98
Filing a Formal Dispute 99
Second Level Dispute Resolution: 99
Section VI Provider Services ***101***

NaviNet **102**
EDI Technical Support Hotline **103**
Provider Network Management **104**
Provider Demographic Information **105**
Email **105**
Provider Services Department **105**
Claims Issues **106**
Member Services **106**
Section VII Quality Management, Credentialing, and Utilization Management ***108***
Quality Management **109**
Purpose and Scope **109**
Objectives **109**
QM Program Authority and Structure **110**
Credentialing/Recredentialing Requirements **111**
Practitioner and Provider Requirements **111**
Provider Application (other than Facilities) **113**
Facility Requirements **114**
Facility Application **115**
Member Access to Physician Information **115**
Provider Sanctioning Policy **116**
Informal Resolution of Quality of Care Concerns **116**
Formal Sanctioning Process **116**
Notice of Proposed Action to Sanction **116**
Notice of Hearing **117**
Conduct of the Hearing and Notice **117**
Provider's Rights at the Hearing **117**
Appeal of the Decision of the LaCare Peer Review Committee **117**
Summary Actions Permitted **118**
External Reporting **118**
Utilization Management Program **118**
Annual Review **118**
Scope **119**

Medical Necessity Decision Making....119
Clinical Practice Guidelines (PENDING MULTI PLAN AGREEMENT) 120
Hours of Operation 121
Timeliness of UM decisions 121
Physician Reviewer Availability to Discuss Decision 122
Denial Reasons 122
Appeal Process 122
Evaluation of New Technology 122
Evaluation of Member & Provider Satisfaction and Program Effectiveness 122
Section VIII Special Needs & Case Management....124
Integrated Care Management (Health Education and Management) 125
Pediatric Preventive Health Care 125
Episodic Care Management 125
WeeCare (Maternity Management) 125
Complex Care Management 125
Rapid Response Team 126
Special Needs....126
WeeCare Program for Pregnant Members 127
Pediatric Preventive Health Care Program....128
Chronic Condition Management Programs 128
Outreach & Health Education Programs 129
Tobacco Cessation 129
Gift of Life 129
Domestic Violence Intervention 129
The Provider's Role 130
Early Steps (Early Intervention System) 130
Specialists as PCPs for Special Needs Members 131
Section IX Member Rights and Responsibilities....132
Member Rights & Responsibilities 133
Member Rights 133
Member Responsibilities 134
Patient Self-Determination Act 135

Section X Provider Medical Necessity Appeals Member Appeals, Complaints & Grievances 136

Provider Medical Necessity Appeals 137

Formal Provider Appeals Process 137

First Level Appeal Review 138

Filing a Request for a First Level Appeal Review 138

Physician Review of a First Level Appeal 138

Time Frame for Resolution of a First Level Appeal 138

Second Level Appeal Review 139

Filing a Request for a Second Level Appeal Review 139

Appeal Panel Review of a Second Level Appeal 139

Time Frame for Resolution 140

Member Grievance and Appeal Process 140

Standard Grievance 141

Appeal Procedures 142

Standard First Level Appeals 142

Standard Second Level Appeals 143

Expedited Appeals 144

Fair Hearing Procedures 145

Standard Fair Hearing 145

Section XI Regulatory Provisions 147

Access to and Financial Responsibility for Services 148

Member's Financial Responsibilities 148

Services Provided by a Non-Participating Provider 148

Services Provided Without Required Referral/Authorization 148

Services Not Covered by LaCare 148

Member Accessibility to Providers for Emergency Care 149

Compliance with the HIPAA Privacy Regulations 149

Allowed Activities Under the HIPAA Privacy Regulations 149

Contact Information 150

Cultural Competency 150

LaCare's Corporate Confidentiality Policy 151

Procedure 153
Provider Protections 154
Additional Resources 155
Section XII ***157***
DENTAL 158
Medicaid - Age 0–21 158
Pregnant with No Dental Insurance 158
Adult Denture Program 159
Early Steps (Early Intervention System) 159
PHARMACY 160
Preferred Drug Listing and Prior Authorization Process 160
Care Coordination: Managing Member Inquiries Concerning Pharmacy Benefit - (Quick Reference) 161
Co-Payments 161
Coverage for OTC drugs, items and supplies 162
Diabetic Testing Supplies 163
Smoking Cessation: 163
Lost or Stolen Medications 163
Early Refill 163
Emergency Supplies (for medications requiring prior authorization) 164
Out-of-State Pharmacy Coverage 164
Nutrition Therapy 164
Lock-In Program 165
TOBACCO CESSATION 165
TOBACCO CONTROL INITIATIVE (TCI) 166
Louisiana Tobacco Control Program Tobacco Smoking Cessation Support Services - Medicaid Recipients/Support Groups 167
Louisiana Tobacco Control Program Tobacco Smoking Cessation Support Services - Providers and Clinicians 168
WIC BASICS 169
COMMUNITY/HUMAN SERVICES RESOURCES 170
Appendix ***197***
Important Definitions 198

Important Forms (Appendices).....208

Introduction

About LaCare

Who We Are

LaCare is the Medicaid managed care program of AmeriHealth Mercy of Louisiana, Inc. and part of the AmeriHealth Mercy Family of Companies, one of the largest organizations of Medicaid managed care plans in the United States. LaCare, headquartered in Baton Rouge, Louisiana, is a mission driven health care organization that helps people get care, stay well and build healthy communities.

Our Values

Our service is built on these values:

Advocacy

Care of the Poor

Compassion

Competence

Dignity

Diversity

Hospitality

Stewardship

Provider Services 888-922-0007

www.lacarelouisiana.com

Important LaCare Telephone Numbers

Department	Phone	Fax
24 Hour Nurse Line	888-632-0009	
Behavioral Health Services	DHH #'s or new MCO	
Complex Care Management	888-643-0005	866-426-7309
Credentialing Department	888-913-0349	866-242-3461
Dental Benefits (Under 21)	DHH	
Enhanced Dental Benefit (21 and older)	800-508-6785	
DME/Outpatient Therapy Unit	888-913-0350	866-397-4522
EDI Technical Support Unit	866-428-7419	
EMDEON Provider Support Line	800-845-6592	
ER Hospital Admission	888-913-0350	866-397-4522
Home Infusion		
Injectable Prior Authorization (pharmaceuticals over $250 when administered in an office/outpatient setting)–		
LaCare Special Programs (Family Planning)		
LaCare Fraud & Abuse Hotline	866-833-9718	
NON EMERGENCY TRANSPORTATION (MTM)	888-913-0364	
Medical Director Hotline		
Member Services Department	888-756-0004	866-397-4521
Outreach & Health Education Programs	888-643-0005	866-426-7309
Pediatric Preventative Health Care Program (Known as EPSDT)	888-643-0005	866-426-7309
Louisiana REVS Eligibility Verification System	800-776-6323	
Pharmacy Services Administered by Louisiana Medicaid	800-437-9101	
Pharmacy Prior Authorization (Specialty Drugs-J codes on Professional Fee Schedule)	855-452-9131	
Prior Authorization	888-913-0350	866-397-4522

Department	Phone	Fax
Provider Claim Services Unit	888-922-0007	866-426-7393
Provider Network Management	877-588-2248	
Provider Services Department	888-922-0007	866-426-7393
Quality Management		
Rapid Response	888-643-0005	877-724-4838
Special Needs Case Management	888-643-0005	866-426-7309
Supply Request Form		
Transportation Unit (LaCare)	888-913-0364	
TTY - Telecommunications for the Hearing Impaired	866-428-7588	
Utilization Management (Main Toll Free Number) Direct Dial Team Numbers: Adult Concurrent Review Pediatric Concurrent Review NICU Review OB Concurrent Review Maternity Data (WeeCare) Discharge Notification Discharge Planning	888-913-0350 888-913-0350 888-913-0350 888-913-0350 888-913-0350 888-913-0327 888-913-0350 888-913-0350	866-397-4522 866-397-4522 866-397-4522 866-397-4522 866-397-4522 888-877-5925 866-397-4522 866-397-4522
Vision Benefit Administrator	800-877-7195	
WeeCare (Maternity Management)	888-913-0327	888-877-5925
Vaccines for Children Program	504- 838-5300	

LaCare understands that our success and successful healthcare strategies are dependent on a true partnership and collaboration with our provider networks. LaCare has contractual relationships with our providers pursuant to which our providers operate as independent contractors to provide services to LaCare members in exchange for an agreed upon fee. LaCare has no ownership interest in our network providers. LaCare directs its members to specific providers or groups of providers according to geographic access standards, member cultural or language preferences/needs and the appropriate provider type/specialty to meet the medical needs of the member. Members are given a choice of at least two providers from which to obtain services

LaCare will implement Regional Provider Councils in Louisiana as a forum to give providers a voice in our programs. Through the Councils, providers and other stakeholders offer input and direction regarding LaCare's policies, procedures and programs, including mechanisms LaCare can use to influence member behavior.

For information on becoming a member of a Regional Provider Council, please contact your Network Development Representative

Provider's Bill of Rights

Every provider in LaCare's Network is assured of the following rights:
A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and State Fair Hearing procedures.
- To have access to LaCare's policies and procedures covering the authorization of services.
- To be notified of any decision by the CCN to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- To challenge, at the request of the Medicaid/CHIP member on their behalf, the denial of coverage of, or payment for, medical assistance.
- The CCN's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.

Provider Demographic Information

Accurate provider information is imperative to successful participation in our network. Correct phone numbers and addresses are necessary for our members to make appointments and find your office location. Correct NPIs, Tax IDs and remittance addresses are necessary for you to be properly reimbursed for your services. Once you receive your welcome letter, we ask that you go to our online provider directory at www.lacarelouisiana.com and verify your provider information is accurate. LaCare periodically provides a report containing the demographic information we have on file. Please review this information and notify us of needed corrections. It is necessary for you to notify us of changes in your provider information so claims can be paid accurately. We must send updated information to the enrollment broker so members are accurately assigned to a PCP.

Email

LaCare frequently issues email notices so please provide you current email address to the Network Management Department.

Section I
Physician Office Standards & Requirements

PCP Reimbursement

PCP Fee-For-Service Reimbursement

Fee-for-service PCP reimbursement is the payment methodology used by LaCare. Reimbursement is in accordance with the Louisiana Physician Fee schedule available online.

Member Linkage to PCP

LaCare feels a good relationship with a PCP is necessary. As a result, LaCare does not "lock" members into a PCP; they may change PCPs at any time.

Completing Medical Forms

In accordance with policy, if a medical examination or office visit is required to complete a form, then you may not charge LaCare members a fee for completion of the form. Payment for the medical examination or office visit includes payment for completion of forms.

However, you may charge LaCare members a reasonable fee for completion of forms if a medical examination or office visit is not required to complete the forms. Examples include forms for Driver Licenses, Camp and/or School applications, Working Papers, etc. You must provide LaCare members with advance written notice that a reasonable fee will be charged for completing forms in such instances. However, if a LaCare member states that it will be a financial hardship to pay the fee, you must waive the fee.

The following physical examinations and completion of related forms are not covered by LaCare:

- Federal Aviation Administration (Pilot's License)
- Return to work following work related injury (Worker's Compensation)

KIDMED Program (EPSDT)

PCPs who participate with LaCare must participate in the Louisiana KIDMED Program.

KIDMED is the screening component of one of Louisiana's Early Periodic Screening, Diagnosis and Treatment (EPSDT) Programs. EPSDT provides preventive health screening, diagnosis, and treatment services for suspected vision, hearing, dental and medical problems. Louisiana has been nationally recognized as having one of the top five EPSDT programs in the nation, exceeding goals for EPSDT participation set by the Center for Medicare and Medicaid Services (CMS). EPSDT services are available to Medicaid-eligible children under the age of 21. EPSDT benefits end on the child's 21st birthday. (For more info on EPDST see page 72)

If you are not enrolled as a KIDMED provider, enrollment forms are available at

http://www.la-kidmed.com/PublicationsAndForms.aspx. To view the KidMed Periodicity Schedule, and Immunization Schedule, see Appendix 1 and Appendix 4 in this manual.

Vaccines for Children Program (VFC)

PCPs treating members up to age 18 must participate in the Vaccine for Children (VFC) Program. The VFC Program provides publicly purchased vaccines for children birth through 18 years of age who are:

- Medicaid enrolled (including Medicaid managed care plans)
- Uninsured (have no health insurance) or
- American Indian/Alaskan Native

Please contact the Louisiana Department of Health and Hospital-Office of Public Health Immunization Program to enroll in the VFC Program, or for other inquiries about the VFC Program such as:

- Program guidelines and requirements
- VFC forms and instructions for their use
- Information related to provider responsibilities
- The latest VFC Program news
- Instructions for enrolling in the VFC Program

Providers participating in VFC must also enter immunization information into the Louisiana Immunization Network for Kids Statewide (LINKS) immunization registry.

Louisiana Immunization Network for Kids Statewide (LINKS)

LINKS is a computer-based system designed to keep track of immunization records for providers and their patients.

The purpose of LINKS is to consolidate immunization information among health care providers to assure adequate immunization levels and to avoid unnecessary immunizations. LINKS can be accessed through the OPH website: https://linksweb.oph.dhh.louisiana.gov.

LINKS will assist providers within their medical practice by offering:

- Immediate records for new patients
- Decrease staff time spent retrieving immunization records
- Avoid missed opportunities to administer needed vaccines
- Fewer missed appointments (if the “reminder cards and letter” option is used)
- LINKS will assist patients by offering:
- Easy access to records needed for school and child care
- Automatic reminders to help in keeping children’s immunizations on schedule
- Reduced cost (and discomfort to child) of unnecessary immunizations

Providers can obtain an enrollment packet, learn more about LINKS or the VFC Program by calling the Louisiana Department of Health and Hospitals, Office of Public Health Immunization Program at (504) 838-5300.

LaCare also posts the most current immunization schedule on our website. See Appendix 2 and 3 in this manual for the Louisiana Immunization Policies and Procedures Manual and the Louisiana DHH Immunization Schedule.

Your Role as PCP

The PCP is the member's starting point for access to all health care benefits and services available through LaCare. Although the PCP will treat most of a member's health care concerns in his or her own practice, LaCare expects that PCPs will refer appropriately for both outpatient and inpatient services while continuing to manage the care being delivered.

All instructional materials provided to our members emphasize the role of the PCP and recommend they seek advice from their PCP before accessing medical care from any other source.

The PCP, or the designated back-up practitioner, should be accessible 24 hours per day, seven days per week, at the office site during all published office hours, and by phone or answering service after hours.

The PCP may not provide our members with any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public. LaCare members may not be subject to discriminatory practices such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients. Providers may not deny to a member any covered service or availability of a facility. Members must be provided all covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated.

When the PCP uses an answering service or answering machine to intake calls after normal hours, the following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care
- All calls answered by an answering service must be returned within 30 minutes
- If the PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP, someone must be available to answer the designated provider's telephone. Another recording is not acceptable. .If the PCP's office telephone is transferred after office hours to another location where someone will answer the telephone, they must be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.
- It is not acceptable to have a message on an answering machine that instructs the Member to go to the emergency room for care without providing instructions on how to reach the PCP.

Appointment scheduling should allow time for the unexpected urgent care visit. (See "Access Standards for PCPs" in this section of the Manual)

- PCPs should perform routine health assessments as appropriate to a patient's age and sex, and maintain a complete individual member medical record of all services provided to the member by the PCP, as well as any specialty or referral services
- PCPs should communicate with other levels of care (primary care, specialty outpatient care, emergency and inpatient care) to coordinate, and follow up the care of individual patients.

- PCPs should discuss plans for future pregnancy with female Members who are able to become pregnant. This discussion should occur during the provision of routine gynecologic care, and/or other health care encounters where the Practitioner feels pregnancy planning is important. Based on the Member's desire to become pregnant, the Practitioner should assist the Member in obtaining appropriate family planning and/or health services to assist the Member in achieving her plan with optimal health status
- PCPs should provide the level of care and range of services necessary to meet the medical needs of its members, including those with special needs and chronic conditions.
- PCPs should monitor and follow-up on care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid FFS.
- PCPs should maintain a medical record of all services rendered by the PCP and other referral providers; and
- PCP's should Coordinate case management services including, but not limited to, performing screening and assessment, developing a plan of care to address risks and medical needs and basic behavioral health services such as screening, prevention, early intervention, medication management, and referral services.
- PCPs should coordinate the services LaCare furnishes to the member with the services the member receives from any another CCN during transition of care.
- PCPs should share the results of identification and assessment of any member with special health care needs (as defined by DHH) with another CCN to which a member may be transitioning or has transitioned so that those activities need not be duplicated.
- PCPs should ensure that in the process of coordinating care, each enrollee's privacy is protected.

School-based health services often play a pivotal role in ensuring that children receive the health care they need. PCPs are required, with the assistance of LaCare, to coordinate and/or integrate into the PCP's records any health care services provided by school-based health services. LaCare's Special Needs managers help by coordinating services between Parent/Guardian, PCP and other practitioners/providers. Call **888-922-0007** and ask to be transferred to the EPSDT liaison should you need assistance.

PCPs are required to provide examinations for LaCare members who are under investigation by the County Children and Youth System for suspected child abuse or neglect. Services must be performed in a timely manner.

Members have the right to access all information contained in the medical record unless access is restricted for medical reasons.

Patient Centered Medical Home

LaCare appreciates the tremendous commitment and progress the State of Louisiana has invested towards the establishment of Patient-Centered Medical Homes. LaCare shares the same goals and commitment and wants to work with our PCPs to help them receive Patient Centered Medical Home certification through NCQA or JCAHO. Through this commitment, we will support and encourage efforts to monitor, track and improve the quality of the care provided to patients.

The Medical Home Concept is:

- ✓ An approach to providing comprehensive primary care
- ✓ Taking personal responsibility & accountability for the on-going care of patients
- ✓ Physicians accessibility to their patients on short notice (expanded hours and open scheduling)
- ✓ Physicians able to conduct consultations through email and telephone
- ✓ Utilizing the latest health information technology and evidence-based medical approaches as well as maintaining updated electronic personal health records
- ✓ Conducting regular check-ups with patients to identify health crises, and initiate treatment/prevention measures before costly, last minute emergency procedures are required
- ✓ Advising patients on preventive care based on environmental and genetic risk factors they face
- ✓ Helping patients make healthy lifestyle decisions
- ✓ Referring members to medically necessary specialty or sub-specialty care
- ✓ Coordinating care, when needed, making sure procedures are relevant, necessary and performed efficiently

LaCare can immediately assist our network PCPs in meeting the PCMH requirements in the following ways:

Access and Communication

Programs to assist providers in this area:

- Transportation assistance and coordination
- Our 24/7 Customer Service Contact Center
- Multi-cultural health information available online
- Handbooks in multiple languages,
- Website in the predominant language (other than English) in the area,
- Translation and interpreter assistance

Patient Tracking and Registry Functions

LaCare will assist providers with data to allow them to know our members individually, and to also collect demographic and clinical data for purposes of population management. Through NaviNet, PCPs will have a 360 degree view of their LaCare linkages/panels with access to clinical information about their members. PCPs can access the Member Clinical Summary that shows all medical services including those from other providers and specialists that an individual member has received. The Member Clinical Summary can be printed for inclusion in the patient's chart or downloaded as a Continuity of Care Document (CCD) for integration into an electronic medical record.

A simple check of eligibility will notify a provider if that member is missing a recommended preventive care or chronic care monitoring service. If there are gaps in a member's care, a message will display alerting the PCP to the needed service.

In addition, PCPs will be able to access this information at the panel level, allowing them to use population management techniques within their practice. This panel-level information is available as a printable report or a CSV (Comma Separated Value) file for compatibility with other electronic systems.

Care Management

LaCare has an array of care management employees who support our providers in assisting members with special needs, chronic care needs and disease specific conditions. Please see Chapter VIII for a full description of our Integrated Care Management programs. PCP involvement in such programs isneeded for successful implementation..

Providers who are treating members/consumers that participate in the Integrated Care Management program have the right to:

- Obtain information about LaCare including its programs and services, its staff and its staff qualifications
- Be informed of how LaCare coordinates its interventions and plan of care for individual members
- Know how to contact the Care Manager who is responsible for managing the case, and communicating with the practitioner's patients
- Be supported by LaCare and work collaboratively in decision making with members/consumers regarding their health care
- Receive courteous and respectful treatment from LaCare staff, and communicate complaints to LaCare.

Providers are responsible to participate in the program through:

- Providing relevant clinical information, as requested
- Taking action to follow-up on reported information
- Participating in the member/consumer plan of care

Pediatric Preventive Health Care

LaCare's Pediatric Preventive Health Care Program (PPHC) (also known as KidMed) is designed to improve the health of members under age 21 by increasing adherence to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program guidelines through the identification and coordination of preventive services. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs through Gaps in Care alerts.

Episodic Case Management

The Episodic Care Management (ECM) program provides coordination of services to new adult and pediatric members to LaCare and existing members with short-term and/or intermittent needs who have single problem issues and/or multiple co-morbidities.

WeeCare (Maternity) Program

The WeeCare (Maternity) Program is managed by a dedicated team of Care Managers and Care Connectors. WeeCare staff outreaches and engages pregnant members into the program based on internal and external assessments that place them into high and low risk categories. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental screenings and depression screenings.

Complex Care Management

Members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member/caregiver and the physician.

Rapid Response Team

Rapid Response (RR) is an important component of the ICM model. The Rapid Response (RR) team was developed to address the urgent needs of our members and to support our providers and their staff. The RR consists of registered nurses, social workers, and non-clinical Care Connectors.

Patient Self-Management and Support

LaCare offers educational materials, reminders, and other forms of support for patient self-management programs. Examples include:

- Healthy Hoops® is an innovative health education program that uses basketball as a platform to help children with asthma and their families learn about the disease and how to manage it through appropriate nutrition, medication use, and monitored exercise.
- "Lose to Win" Diabetes and Weight Management Program is anaward winning 12-week program that helps members with type-2 diabetes learn the importance of regular exercise, eating a balanced diet and living a healthy lifestyle.
- The Women's Health Ministry Program was created to provide health and wellness information in a faith-based environment – including churches, synagogues and mosques – thus providing women and their families with a safe, supportive setting to learn about their health and receive needed health screenings
- There is also a Resource Guide in CHAPTER XII prepared by the Louisiana Department of Health and Hospitals (DHH) which list community and government organizations that can assist patients with social and economic issues that may adversely effect health status.

Performance Reporting and Improvement

Through comprehensive profiling LaCare offers providers the ability to track their performance across multiple metrics: HEDIS measures, hospitalizations and ER utilization are some examples. We are available to provide education to our providers about how to access the data available through the Provider Portal.

Below are links to more information about the standards and certification requirements from NCQA or JCAHO.

http://www.jointcommission.org/what_you_need_to_know_about_joint_commisison_primary_care_medical_home/

http://www.ncqa.org/tabid/631/Default.aspx

The PCP Office Visit

It is imperative that PCPs verify member eligibility prior to rendering services to LaCare members. For complete instructions on verifying eligibility, please refer to the "**Member Eligibility**" Section of the Manual for additional information.

Physician Coverage

If a member is assigned/linked to a specific PCP and he or she is not available, there are no additional coverage requirements for PCPs in the same group. As long as the member is seen by a PCP in the same group, with the same tax ID any claim resulting from the visit is paid.

Access Standards for PCPs

LaCare has established standards to assure accessibility of medical care services. The standards apply to PCPs and are requirements of the PCP contract.

Appointment Accessibility Standards

Appointment Accessibility Standards	
Medical Care:	**LaCare Standard:**
Routine/Preventative Primary Care must be scheduled	Within 6 weeks of the member's call
Non-Urgent Sick Visits	Within 72 hours or sooner if condition deteriorates
Urgent Medical Condition Care must be scheduled	Within 24 hours of the member's call
Emergency Medical Condition Care must be seen	Immediately upon the member's call or referred to an emergency facility
After-Hours Accessibility Standards	
Medical Care:	**LaCare Standard:**
After-Hours Care by a PCP or a covering PCP must be available *	24 hours/7 days a week

*When the PCP uses an answering service or answering machine to intake calls after normal business hours, the call must be answered by ten (10) rings, and returned within 30 minutes. The following information must be included in the message:

- Instructions for reaching the PCP
- Instructions for obtaining emergency care

PCPs are to contact all new panel members for an initial appointment. LaCare has Special Needs and Care Management Programs that contact members with the following conditions.

- Pregnant members
- Members with chronic conditions, including:

- Asthma
- Diabetes
- COPD
- Heart failure
- Sickle Cell Disease.

PCPs are required by their contract to schedule appointments in a timely manner.. PCPs must inform LaCare if he/she learns that a member is pregnant so they can be included in the LaCare maternity program. Please call 888-922-0007to refer a member to the LaCare WeeCare Program and/or for assistance in locating an OB/GYN practitioner. (OB/GYN services do not require a referral.)

We encourage our providers to offer evening and Saturday hours. LaCare will offer the additional reimbursement offered under the Medicaid Professional Fee Schedule when Physicians bill the adjunct codes 99050 (weekday evening hours) and 99051 (weekend and holiday hours).

Initial Examination for Members who are pregnant	Appointment Scheduled with an OB/GYN practitioner
Pregnant women in their 1st trimester	Within 14 business days of LaCare learning the member is pregnant.
Pregnant women in their 2nd trimester	Within 7 business days of LaCare learning the member is pregnant.
Pregnant women in their 3rd trimester	Within 3 business days of LaCare learning the member is pregnant.
High-risk Pregnant Women	Within 3 days of LaCare learning the member is high risk or immediately if an Emergency Medical Condition exists.

Additional Requirements of PCPs

1. The average waiting time for scheduled appointments must be no more than 45 minutes (including time in the waiting room and examining room) unless the PCP encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. In such cases, waiting time should not exceed one (1) hour. If a provider is delayed, patients will be notified immediately. If the wait is over ninety (90) minutes, the patient must be offered a new appointment.
2. Walk-in patients with non-urgent needs should be seen if possible, or scheduled for an appointment consistent with the above standards.
3. Patients must be scheduled at the rate of six (6) patients or less per hour
4. The PCP must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record. PCPs should be aware that we offer transportation assistance for our members and assistance getting to appointments can be gotten by calling our transportation unit at 888-913-0364. Should the PCP encounter members who habitually miss appointments, please contact our Rapid Response Team. Our RR Care Connectors will contact the member

to counsel and educate them about the importance of keeping appointments. LaCare will also conduct quarterly surveys to monitor the no-show rate.

5. Number of regular office hours must be greater than or equal to 20 hours per week
6. Telephonic response time (call back) for non-emergency conditions should be less than two (2) hours
7. Telephonic response time (call back) for after-hours/emergency conditions must be less than 30 minutes
8. Member medical records must be maintained in an area that is not accessible to those not employed by the practice. Network providers must comply with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, obtaining any required written member consents to disclose confidential medical records.
9. 24 hour/ 7 days per week coverage must be available via the PCP for Urgent and Emergency Medical Condition care. An answering machine message that does not answer the call by 10 rings or provide instructions on how to reach the PCP does not constitute coverage. For example, it is not acceptable to have a message on an answering machine that instructs the member to go to the emergency room for care without providing instructions on how to reach the PCP.
10. If a member presents to the PCP in need of emergency behavioral health services, the provider shall instruct the member to seek help from the nearest emergency medical provider. The PCP is asked to notify our Rapid Response Unit at 888-643-0005 who will follow up with the Behavioral MCO to assure the member was referred for services.
11. PCPs must comply with all Cultural Competency standards. Please refer to "**PCP & Specialist Office Standards**" in this Section of the Manual, as well as the "**Regulatory Provisions**" Section of the Manual for additional information on Cultural Competency.
12. If as member changes PCPs or CCN plans, the PCP will forward a copy of the member's medical record and supporting documentation to the new PCP within ten (10) business days of the receiving PCP's request.
13. PCPs are prohibited from making referrals to healthcare entities with which they, or a member of their family has a financial relationship

Please refer to "PCP & Specialist Office Standards" in this section of the Manual for further information on the following practitioner standards:

- Medical Record Standards
- Physical Office Layout

LaCare monitors compliance with appointment standards in a variety of ways: During visits by your Provider Network Representative, monitoring member complaints, telephone surveys, and "mystery shopper" calls. On an annual basis, LaCARE monitors the compliance of all participating

PCP Offices against the established Accessibility Standards. The data collected to monitor for compliance include Appointment Access to Data Only, After-Hours Access Data Only, and Appointment Access and After-Hours Access Data. All non-compliant providers are notified of all categories requiring improvement. The non-compliant providers are given a timeline for submitting a corrective action to meet the performance standards.

PCP Selection

During the enrollment process, members work with the Enrollment Broker to choose a CCN and a PCP. If the member does not select a PCP at the time of enrollment, LaCare has a process to ensure the member is assigned to a PCP. If the member does not select a PCP within 10 days of enrollment in LaCare, we will assign the member to a PCP. LaCare will do the following:

- Identify the most recent PCP utilized by the member and determine whether that PCP is in the LaCare Provider Network
- Identify a PCP in the LaCare Provider Network utilized by someone in the member's family. If appropriate, LaCare will assign the member to that PCP.
- If none of these options are appropriate, LaCare will select a PCP from or close to the member's zip code.

Members can choose another PCP at any time by calling Member Services at 888-756-0004.

Additionally, members are encouraged to select a Pediatrician/PCP for their newborn prior to the baby's birth ideally before the beginning of the member's last trimester of gestation.. The member can enroll their newborn with a PCP by calling Member Services at **888-756-0004**. Our WeeCare staff will also stress the need for pediatrician selection and assist the member. Should a member fail to choose a pediatrician prior to the baby's birth, LaCare will assign the baby to a pediatrician - unless the mother's current PCP is a family practitioner in which case, we will assign the baby to the mother's PCP.

It is the PCP's responsibility to contact the Provider Services Department prior to rendering services to a member who has not yet selected a PCP.

Referrals

The PCP may need to refer members for specialist care. PCPs may provide electronic referrals to Network Specialists through NaviNet, our Provider Portal (see Chapter IV for more information on using NaviNet) or LaCare members must obtain a pre-numbered paper referral form from their assigned PCP. For further information on authorizations and referrals, see "Referral Process" in Section IV of the Manual.

In order to expedite the ordering of forms and other printed materials from LaCare, a Fax Request process has been developed. The Referral Supply Request Form (see Appendix 7 in this Manual for a sample Referral Supply Request Form) should be faxed to our toll-free number, **FAX LINE**, which will go directly to our supply warehouse. Fax orders received before 12 noon on a business day will be filled and shipped the same day. Orders received after 12 noon on a business day will be filled and shipped the next business day. If you experience difficulty in faxing a request, or have questions about an order, our warehouse coordinator is available to assist you by calling **215-937-8800**.

Tertiary Care Services

LaCare has tertiary care facilities in our network. Tertiary care is care provided by highly specialized providers, such as medical sub-specialists and frequently require advanced technological and support facilities such as trauma centers, burn centers, high risk Neo Natal Intensive Care units, rehabilitation facilities, and other medical sub specialties. Many of these services are located at medical centers and are often accessed in cases of emergency and need no referral. When a member needs such services on a non emergent basis or follow up care after an emergency, the PCP should issue a referral and/or obtain prior authorization (if required). If the specialty required is not in our network, please refer to Out-of-Plan referrals on page 51.

Forms/Materials Available

Fax a Supply Request Fax Form into LaCare's warehouse at **FAX LINE** to order supplies of the following forms or printed materials:

- Supply Request Fax Form
- Provider Directory*
- Provider Manual
- Pre-numbered Referral Form
- Hospital Notification of Emergency Admissions Form

Additional printed forms and materials are often added to our inventory. If you do not see the form or item you need in the above listing or on the Referral Supply Request Form, please contact the Warehouse Coordinator to check on the item's availability.

* Real time Provider information is available on www.lacarelouisiana.com as well as many of these forms.

Visit Reporting

CMS defines an Encounter as "an interaction between an individual and the health care system." Encounters occur whenever a LaCare member is seen in a practitioner's office, whether the visit is for preventive health care services or for treatment due to illness or injury. An Encounter is any health care service provided to a LaCare member. Encounters must result in the creation and submission of an Encounter record (CMS-1500 form or electronic submission) to LaCare. The information provided on these records represents the Encounter data provided by LaCare to the Louisiana Medicaid Program.

Completion of Encounter Data

PCPs must complete and submit a CMS-1500 form or file an electronic Claim every time a LaCare member receives services. Completion of the CMS-1500 form or electronic Claim is important for the following reasons:

- It provides a mechanism for reimbursement of medical services, including payment of inpatient newborn care and attendance at high risk deliveries
- It allows LaCare to gather statistical information regarding the medical services provided to LaCare 's members, which better support our statutory reporting requirements
- It allows LaCare to identify the severity of illnesses of our members

LaCare can accept Claim submissions via paper or electronically (EDI). For more information on electronic Claim submission and how to become an electronic biller, please refer to the "EDI Technical Support Hotline" topic in Section V of the Manual or the Claims Filing Instructions in the Provider Center online at www.lacarelouisiana.com.

In order to support timely statutory reporting requirements, we encourage PCPs to submit claims within 30 days of the visit. However, all claims must be submitted within 12 months from the date services were rendered or compensable items were provided.

The following mandatory information is required on the CMS-1500 form for a primary care visit:

- LaCare member's ID number
- Member's name
- Member's date of birth
- Other insurance information: company name, address, policy and/or group number, and amounts paid by other insurance, copy of EOBs
- Information advising if patient's condition is related to employment, auto accident, or liability suit
- Name of referring physician, if appropriate
- Dates of service, admission, discharge
- Primary, secondary, tertiary and fourth ICD-9-CM diagnosis codes, coded to the correct 4th or 5th digit
- Authorization or referral number
- CMS place of service code
- HCPCS procedures, service or supplies codes; CPT procedure codes with appropriate modifiers
- Charges
- Days or units
- Physician/supplier federal tax identification number or Social Security Number
- National Practitioner ID (NPI) and Taxonomy Code
- Individual LaCare assigned practitioner number (we cannot require but can ask)
- Name and address of facility where services were rendered
- Physician/supplier billing name, address, zip code, and telephone number
- Invoice date

Please see "Claims Filing Instructions" in Section VI of the Manual for additional information for the completion of the CMS form.

LaCare monitors Encounter data submissions for accuracy, timeliness and completeness through Claims processing edits and through network provider profiling activities. Encounters can be rejected or denied for inaccurate, untimely and incomplete information. Network providers will be notified of the rejection via a remittance advice and are expected to resubmit corrected information to LaCare. Network providers may also be subject to sanctioning by LaCare for failure to submit accurate Encounter data in a timely manner.

The Provider Services Department at **888-922-0007** can address questions concerning claims submission and there is a billing manual online in the provider section of the LaCare website - www.lacarelouisiana.com.

Transfer of Non-Compliant Members

By PCP request, any member whose behavior would preclude delivery of optimum medical care may be transferred from the PCP's panel. LaCare's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with his/her PCP.

A written request on your letterhead asking for the removal of the member from your panel must be sent to the Provider Services Department that includes the following:

- The member's full name and LaCare identification number
- The reason(s) for the requested transfer
- The requesting PCP's signature and LaCare identification number

Transfers will be accomplished within 30 days of receipt of the written request, during which time the PCP must continue to render any needed emergency care.

The Provider Services Department will assign the member to a new PCP and will notify both the member and requesting PCP when the transfer is effective. The Provider Services Department Telephone Number is **888-922-0007**.

Requesting a Freeze or Limitation of Your Member Linkages

LaCare recognizes that a PCP will occasionally need to limit the volume of patients in his/her practice in the interest of delivering quality care. Each PCP office must accept at least 50 members but may specify after 50, the number of members/PCP linkages they will accept from LaCare. Our system will automatically close the PCP Panel once a PCP had reached the specified number of linkages. A PCP may also forward a request to limit or stop assignment of members to his/her panel if his/her circumstances charge.

LaCare must have 90 days advance written notice of any request to change linkages status. For example, a linkages limitation or freeze request received on May 1 would become effective on August 1. When requesting to have members added to panels where age restriction or panel limitations exist, LaCare must be notified in writing on the PCP office's letterhead.

Policy Regarding PCP to Member Ratio

PCP sites may have up to 2500 Medicaid recipient linkages (cumulative across CCNs per each full-time equivalent PCP at the site. For example, if a primary care site has four full-time equivalent PCPs, they can have up to 10,000 CCN eligible members (cumulative across all Medicaid plans). If a PCP employs physician extenders (Nurse Practitioners/Physician Assistants, Certified Nurse Midwives (for OB/GYN only), the maximum may be extended by 1,000 members per extender. If the PCP has more Medicaid members than these maximums, please contact your Provider Network Representative immediately, LaCare may submit a request for an exception to the PCP-to-Patient ration to the Department of Health and Hospitals (DHH).

Confidentiality of Medical Records

Patient medical records must be maintained in an area that is not accessible to those not employed by the practice. Network providers must comply with all applicable laws and regulations pertaining to the confidentiality of member medical records, including obtaining any

required written member consent to disclose confidential medical records. Please refer to "Medical Record Standards" in this section of the Manual for further information on the maintenance of medical records.

Letter of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, PCPs are requested to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a network provider or facility
- Initial documentation submitted is insufficient for LaCare to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the LaCare's Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff person managing the request for services for the member in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The member's name and LaCare identification number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the member
- Other treatment or testing methods, which have been tried but have not been successful along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure that is being requested

Providers are advised that failure to provide medical documentation or respond to requests for medical documentation to establish medical necessity will result in the denial of Prior Authorization. Claims submitted without authorization, when authorization is required, will be denied. LaCare considers it a Quality of Care issue if a member is in need of medically necessary services and the service is not provided because of lack of Prior Authorization when that lack of Prior Authorization is a direct result of the provider's failure to supply medical documentation. If there is a pattern of such action, the provider will be referred to the Quality Management Department. Please see Provider Sanctioning Policy on page 115.

PCP Responsibilities Under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Providers must adhere to State and local law regarding patient self-determination and advance directives regarding decisions about their care and treatment. The member's rights under Louisiana state law, include the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives.

PCPs should be aware of, and discuss, the Patient Self-Determination Act with their adult patients. Specific responsibilities of the PCP are:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked.
- Do not discriminate against the individual based on whether or not she/he has executed an advance directive.
- Ensure compliance with the requirements concerning advance directives

LaCare provides our members with information about the Patient Self-Determination Act via the Member Handbook including their right to file complaints about failure to comply with an advance directive with Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138. Excerpts from the Member Handbook regarding this topic can be found in Section IX of the Manual entitled "Member Rights and Responsibilities."

Preventive Health Guidelines

The Preventive Health Guidelines were adopted from the U.S. Preventive Services Task Force.. As with all guidelines, the LaCare Preventive Health Guidelines are based on recommendations from the U.S. Preventive Services Task Force and are not intended to interfere with a Health Care Provider's professional judgment. The Preventive Health Guidelines are now available in the Provider Center at www.lacarelouisiana.com or you can call your Network Development Representative to request hard copies.

Behavioral Health Screening

The PCP shall provide basic behavioral health services. Basic Behavioral Health services are mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities and fall under CPT codes 99201-99215. PCP's should refer the member to the appropriate health care specialist as deemed necessary for specialized behavioral health services. Behavioral Health services provided by an FQHC are reimbursed as part of the FCHC encounter payment. LaCare will assist in linking members with the Specialized Behavioral Health Care Managed Care Organization. LaCare will also conduct trainings for providers and care managers on identification and screening of behavioral health conditions.

Clinical Practice Guidelines

LaCare has adopted clinical practice guidelines for use in guiding the treatment of LaCare members, with the goal of reducing unnecessary variations in care. LaCare clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

LaCare's Clinical Practice Guidelines are available in the Provider Center at www.lacarelouisiana.com., or you can call your Network Development Representative to request a copy.

In support of the above guidelines, LaCare's Integrated Care Management program is available to assist you in the education and management of your patient with special health needs, chronic diseases or complex conditions. For information, a copy of the clinical guidelines, or to refer a LaCare member for Care Management Services, calls Rapid Response at 888-643-0005.

SAMPLE LISTING PENDING RESOLUTION OF MULTI PLAN AGREEMENT

Condition	Clinical Evidence-Based Guidelines
Diabetes	▪ American Diabetes Association: Clinical Practice Recommendations 2010 http://care.diabetesjournals.org/content/33/Supplement_1
Heart Failure	▪ 2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults http://circ.ahajournals.org/cgi/content/full/119/14e/e391 ▪ Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease http://ahajournals.org/cgi/content/full/115/21/2761
Asthma	▪ Global Initiative for Asthma (GINA) 2009 http://www.ginasthma.com/Guidelineitem.asp??l1=2&l2=1&intId=60 ▪ National Institute of Health (NIH) 2009 http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
COPD	▪ Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2008. http://www.goldcopd.com/guidelineitem.asp?l1=2&l2=1&intId=989
Sickle Cell Disease	▪ National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources: The Management of Sickle Cell Disease http://www.nhlbi.nih.gov/health/prof/blood/sickle/sc_mngt.pdf
Pregnancy	▪ Institute for Clinical Systems Improvement: Routine Prenatal Care, 14th ed. July 2010 http://www.icsi.org/prenatal_care_4/prenatal_care_routine_ful_version_2.html

Primary Care Provider Incentive Plan

LaCare plans to implement a PCP Incentive Program designed to recognize and reward providers who perform better than their peers. The PCP incentive program will be based on quality, access, and operational performance components that will be finalized by the Quality Assessment and Performance Improvement Committee after input from the Regional Provider Councils.

The Regional Provider Councils will select a variety of performance metrics and targets such as quality measures, severity of illness, medical cost management, operations and emergency room utilization. To be eligible for the program, the individual PCP or the PCP group will need a minimum assigned panel of 500 LaCare members. The minimum membership requirements mitigate scenarios where a few high cost cases adversely affect the performance for the entire PCP panel and also ensure a deeper collaborative relationship between LaCare and the practice.

Regional Provider Councils in each Geographic Service Area (GSA) will assist in identifying the exact components of the PCP Incentive Program.

Specialty Care Providers

The Specialist Office Visit

LaCare members receive Specialist (including Subspecialist) services from network providers via a referral from their PCP's office. Specialist services are reimbursed on a fee-for-service basis at the Provider's contracted rate.

Prior to receiving Specialist or Sub-specialist services, LaCare members must obtain a referral from their assigned PCP. Specialists can either check for an approved referral using NaviNet's "Referral Inquiry" option (www.navinet.net), or the member will bring a paper referral form. Prior to rendering services, Specialists should always verify member eligibility, which can be done by checking "Member Eligibility" through NaviNet online at www.navinet.net or by calling Provider Services at **888-922-0007**. For more information, please refer to "Referral & Authorization Requirements" in Section II of this Manual. It is necessary for all network providers to adhere to the applicable office standards as outlined in "PCP & Specialist Office Standards" in this Section.

Reimbursement/Fee-for-Service Payment

LaCare will reimburse all contracted specialists at fee-for-service rates described in the network provider's individual LaCare Specialty Care Provider Agreement**. We encourage our providers to offer evening and Saturday hours. LaCare will offer the additional reimbursement offered under the Medicaid Professional Fee Schedule when Physicians bill the adjunct codes 99050 (weekday evening hours) and 99051 (weekend and holiday hours).**

Please refer to "Claims Filing Instructions" in Section VI of the Manual for complete billing instructions. Should you determine the need for diagnostic testing or procedures requiring authorization, please contact LaCare's Utilization Management Department at **888-913-0350** to obtain authorization.

Referrals are valid for 180 days from the date of request, for unlimited visits. The referral may be extended up to one year, for continued care by the specialist, by calling Provider Services at **888-922-0007**. Date(s) of service must not be prior to the request date.

Specialist/Sub-specialist Services

Specialists and Sub-specialists shall provide Medically Necessary covered services to LaCare members referred by the member's PCP. These services include:

- Ambulatory care visits and office procedures
- Arrangement or provision of inpatient medical care at a LaCare participating hospital
- Consultative Specialty Care Services 24 hours a day, 7 days a week

Counseling and services related to pregnancy planning

Annually, Practitioners should discuss plans for future pregnancy with female Members who are able to become pregnant. This discussion should occur during the provision of routine gynecologic care, and/or other health care encounters where the Practitioner feels pregnancy planning is important. Based on the Member's desire to become pregnant, the Practitioner

should assist the Member in obtaining appropriate family planning and/or health services to assist the Member in achieving her plan with optimal health status.

Specialist Access & Appointment Standards

The average office waiting time should be no more than 45 minutes (including time in the waiting room and examining room), or no more than one (1) hour when the network provider encounters an unanticipated urgent visit or is treating a patient with a difficult medical need. If a provider is delayed, patients will be notified immediately. If the wait is over ninety (90) minutes, the patient must be offered a new appointment.

Scheduling procedures should ensure:

- Emergency appointments immediately upon referral
- Urgent Care appointments within twenty-four (24) hours of referral
- Routine appointments within one month of the referral

The Specialist must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record. PCPs should be aware that we offer transportation assistance for our members and assistance getting to appointments can be gotten by calling our transportation unit at 888-913-0364. When the PCP encounters members who habitually miss appointments, please contact our Rapid Response Team. Our Rapid Response Care Connectors will contact the member to counsel and educate them about the importance of keeping appointments. LaCare will also conduct quarterly surveys to monitor the no-show rate.

If a member presents to the Specialist in need of emergency behavioral health services, the provider shall instruct the member to seek help from the nearest emergency medical provider. All LaCare network providers shall notify the LaCare Care Coordination department when a member is referred to or seeks care for emergency behavioral health concerns. The Care coordination department will follow-up with the Behavioral MCO to assure the member was referred to appropriate services.

Confidentiality of Medical Records

Patient medical records must be maintained in an area that is not accessible to those not employed by the practice. Network providers must comply with all applicable laws and regulations pertaining to the confidentiality of member medical records, including obtaining any required written member consents to disclose confidential medical records. Please refer to "Medical Record Standards" in this section of the Manual for further information on the maintenance of medical records.

Letters of Medical Necessity (LOMN)

In keeping with the philosophy of managed care, health care providers are required to supply supporting documentation to substantiate medical necessity when:

- Services require Prior Authorization
- Services include treatment or diagnostic testing procedures that are not available through accepted medical practice
- Services are not provided by a network provider or facility

- Initial documentation submitted is insufficient for LaCare to make a determination

This is not an all-inclusive listing of circumstances for which supporting medical documentation may be requested. Additional supporting documentation may also be requested at the discretion of the Medical Director or his/her designee.

Supporting medical documentation should be directed to the Utilization Management staff that is managing the case of the patient in question, or to the Medical Director or his/her designee, as appropriate. At a minimum, all supporting medical documentation should include:

- The member's name and LaCare ID number
- The diagnosis for which the treatment or testing procedure is being sought
- The goals of the treatment or testing for which progress can be measured for the member
- Other treatment or testing methods which have been tried but have not been successful, along with the duration of the treatment
- Where applicable, what treatment is planned, if any, after the patient has received the therapy or testing procedure, which is being requested

Providers are advised that failure to provide medical documentation or respond to requests for medical documentation to establish medical necessity will result in the denial of Prior Authorization. Claims submitted without required authorization will be denied. LaCare considers it a Quality of Care issue if a member is in need of medically necessary services and the service is not provided because of lack of Prior Authorization when that lack of Prior Authorization is a direct result of the provider's failure to supply medical documentation. If there is a pattern of such action, the provider will be referred to the Quality Management Department. Please see Provider Sanctioning Policy on page 115.

Specialist Responsibilities Under the Patient Self Determination Act

In 1990, the Congress of the United States enacted the Patient Self-Determination Act. Specialists should be aware of and discuss the Patient Self-Determination Act with their adult patients. Specific responsibilities of the specialist are outlined below:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record, and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked
- Do not discriminate against the individual based on whether or not he/she has executed an advance directive
- Ensure compliance with the requirements concerning advance directives

LaCare provides our members with information about the Patient Self-Determination Act via the Member Handbook. Excerpts from the Member Handbook regarding this topic can be found in "Member Rights and Responsibilities" in Section IX of the Manual.

Specialist as a PCP for Special Needs Members

Refer to page 125 of the Special Needs and Case Management Section.

Specialist Incentive Plan

LaCare plans to implement a Specialist Incentive Plan program for select specialists. The Specialist Incentive Plan will be defined and developed after consultation with the Regional Provider Council. As members are not traditionally assigned to a specialist, incentive programs for these providers tend to focus on a combination of quality metrics and reduction of unnecessary utilization rates. Once finalized, Incentive Plan information will be included in this manual.

PCP & Specialist Office Standards

Physical Environment

The following are examples of standards that must be met for LaCare network participation:

1. Office must be handicapped-accessible*
2. Office must have visible signage
3. Office hours must be posted
4. Office must be clean and presentable
5. Office must have a waiting room with chairs
6. Office must have an adequate number of staff/personnel to handle patient load, with an assistant available for specialized procedures
7. Office must have at least two examination rooms that allow for patient privacy
8. Office must have the following equipment:

- Examination table
- Otoscope
- Ophthalmoscope
- Sphygmomanometer
- Thermometers
- Needle disposal system
- Accessible sink/hand washing facilities
- Bio-hazard disposal system

9. There must be a system in place to properly clean/decontaminate and sterilize reusable equipment. Bio-medical equipment must be part of an annual preventive maintenance program
10. Office must have properly equipped (handicapped-accessible) restroom facilities, readily accessible to patients
11. Patient records must be secured at all times, and not accessible to public areas
12. Must have written procedures for medical emergencies and a written evacuation plan. During patient hours, at least one staff person must be CPR-certified
13. The office must be equipped with at least one fire extinguisher that is properly serviced and maintained
14. Must have blood-borne pathogen exposure control plan
15. Medications must be stored in a secure place away from public areas. Refrigerators used for medication storage must have a thermometer. Controlled substances must be locked, and prescription pads must be kept in a secure place

* Title III of the Americans with Disabilities Act (ADA, 42 U.S.C. 1201 et seq.) states that places of public accommodation must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as health care providers) must specifically comply with, among other things, requirements related to effective physical accessibility, communication with people with hearing, vision, or speech disabilities, and other access requirements. For more information, you can go to the Department of Justice's ADA Home Page www.usdoj.gov/crt/ada/adahom1.htm.

Medical Record Requests

LaCare is required to provide one (1) free copy of any part of member's record upon member's request and we must cover the cost of Medical Record Copies when a member transfers from our plan to another CCN. PCPs and Specialists may not charge a member for such copies but must seek reimbursement from LaCare.

Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.

Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

If the original treatment records are generated, maintained, or stored in paper form, copies shall be provided upon payment of a reasonable copying charge, not to exceed $1 per page for the first 25 pages, $.50 per page for 26 to 350 pages, and $.25 per page thereafter, a handling charge not to exceed $25 for hospitals, nursing homes, and other health care providers, and actual postage. If treatment records are generated, maintained, or stored in digital format, copies may be requested to be provided in digital format and charged at the rate provided for herein; however, the charges for providing digital copies shall not exceed one hundred dollars, including all postage and handling charges actually incurred

Medical Record Standards

Complete and consistent documentation in patient medical records is an essential component of quality patient care. LaCare assures there is an individual medical record for each member exists and it adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations.

LaCare performs an annual medical record review on a random selection of practitioners. The medical records are audited using these standards.

The following is a list of our standards (you can also find the standards online in the Provider Center at www.lacarelouisiana.com)

- Elements in the medical record are organized in a consistent manner, and the records are kept secure and confidential
- Records are safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit
- Records are readily available for review and provides medical and other clinical data required for Quality and Utilization Management review
- Patient's name or identification number is included on each page of record
- All entries are legible, initialed or signed and dated by the author (initials must be identified with a correlating signature)
- Personal and biographical data are included in the record, including date of birth, gender, legal guardianship (if applicable), language spoken by member (and any translation needs)
- Member's immunization status
- Current and past medical history, developmental history (for pediatric patients) and age-appropriate physical exams are documented including serious accidents, operations and illnesses
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA"
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening
- An updated problem list is maintained
- Documentation of discussions of a living will or other advance directive for patients 65 years or older
- For each visit, the record includes:
    - Date and begin and end times of service
    - Clear documentation of the patient's chief complaint or purpose for visit
    - Objective findings, clinical assessment and/or physical findings with appropriate working diagnoses or medical impressions
    - Plans of action/treatment, consistent with diagnosis
    - Treatment and/or therapy prescribed and drugs administered or dispensed
    - Health education provided
    - Name and credentials of the provider rendering the service and the signature or initials of the provider
- There is no evidence the patient is placed at inappropriate risk by a diagnostic procedure or therapeutic procedure
- Unresolved problems from previous visits are addressed in subsequent visits
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate
- Referrals are documented, including follow-up and outcome of the referral
- Documentation includes information on emergency and/or after-hours encounters and follow-up
- Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the network provider and updated as needed
- Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated as appropriate

- Screening and preventive care practices are in accordance with the LaCare Preventive Health Guidelines
- For members under 21 years of age, the record includes:
    - Comprehensive health history
    - Developmental history
    - Unclothed physical exam
    - Age-appropriate vision, hearing and dental screening
    - Appropriate immunizations
    - Appropriate lab testing, including mandatory lead screening
    - Health education and anticipatory guidance
- An immunization record is up to date (for members under 21 years of age) or an appropriate history has been made in the medical record (for adults)
- Signed and dated consent forms are included in the record, as appropriate
- Requests for consultations are consistent with clinical assessment/physical findings
- Laboratory and other studies are ordered, as appropriate
- Laboratory and diagnostic reports reflect network provider review
- Patient notification of laboratory and diagnostic test results and instruction regarding follow-up, when indicated, are documented
- There is evidence of continuity and coordination of care between PCPs and Specialists

Medical Record Retention Responsibilities

Medical records must be preserved and maintained for a minimum of six (6) years from termination of the Health Care Provider's agreement with LaCare or last date of service provided to a member or as otherwise required by law or regulatory requirement. Medical records may be maintained in paper or electronic form; electronic medical records must be made available in paper form upon request.

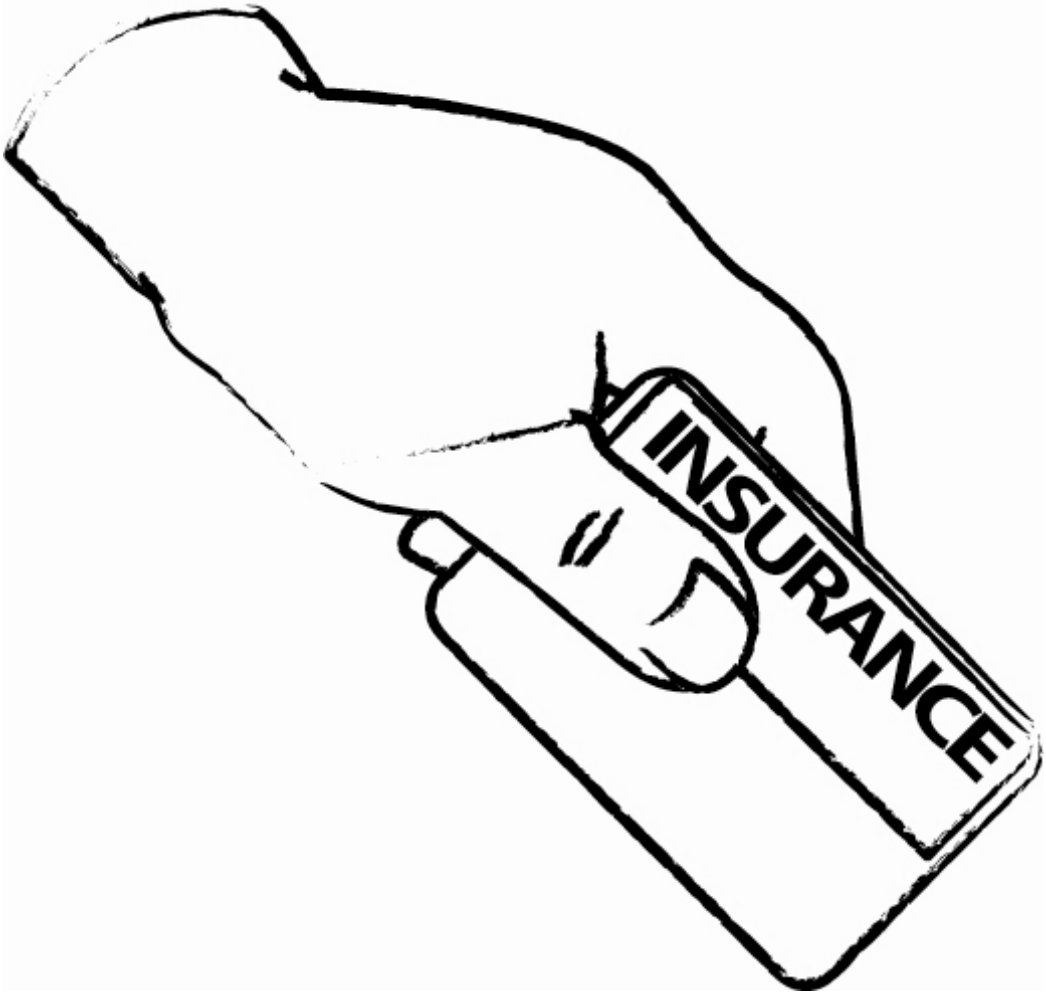
Provider Communications Materials

Network providers who wish to let their patients know of their affiliations with one or more CCNs must list each CCN with whom they have contracts.

Network providers may display and/or distribute health education materials for all contracted CCNs or they may choose not to display and/or distribute for any contracted CCNs. Health education materials must adhere to the following guidance:

- Health education posters cannot be larger than 16" X 24";
- Children's books, donated by CCNs, must be in common areas;
- Materials may include the CCNs name, logo, phone number and website; and
- Providers are not required to distribute and/or display all health education materials provided by each CCN with whom they contract. Providers can choose which items to display as long as they distribute items from each contracted CCN and that the distribution and quantity of items displayed are equitable.

Section II
Member Eligibility



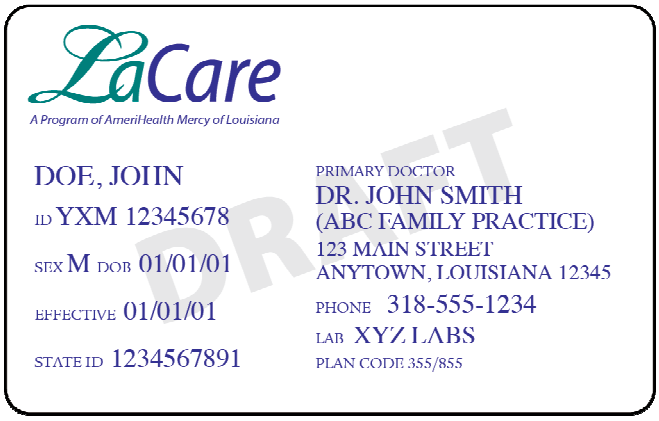
Enrollment Process

Once it is determined that an individual is an eligible Medicaid recipient, an Enrollment Specialist assists the recipient with the selection of a PCP and, as appropriate, a Coordinated Care Network (CNN). LaCare is informed on a daily basis of eligible recipients who have selected LaCare as their CNN. The Enrollee is assigned an effective date by the state and this information is transmitted in the enrollment broker file. The above process activates the release of a **LaCare ID card** and a **Welcome Package** to the member.

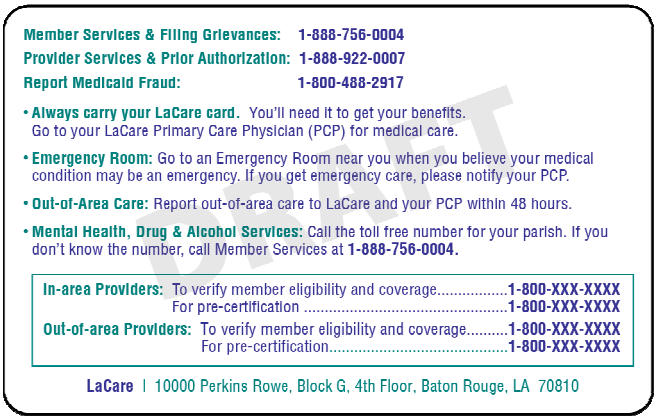
LaCare Identification Card

The LaCare Identification Card lists the following information:

- Member's Name
- LaCare Identification Number
- Member's Sex and Date of Birth
- State ID Number
- PCP's Name and Phone Number
- Co-pays
- Provider Services telephone number - 888-922-0007



Front



Back

Welcome Packet

LaCare's Welcome Packet includes:

- New Member Welcome Letter, containing information on major program features, information on the LaCare identification card and contact information for LaCare
- New Member Handbook which contains:
    - A description of available services
    - A listing of the member's Rights and Responsibilities
    - A listing of the member's Complaint, Grievance and Fair-Hearings Procedures
- Member Benefit Limit and Co-Pay Schedule
- A LaCare Provider Directory
- HIPAA Notice of Privacy Practices and Summary
- A Self-Assessment Health Survey
- Benefits Grid
- Important telephone numbers
- Information about what is available on LaCare's website
- Nurse Call Line magnet
- Personal Health Record Card and Holder
- How and Where to Get Care
- Information about how to receive information in alternative languages or formats

Continuing Care

LaCare provides continuing coverage of care for members who are engaged in an ongoing course of treatment with a non-participating Practitioner/Provider to promote continuity of care in the following situations:

Newly Enrolled Pregnant Women

Who are receiving medically necessary covered services in addition to, or other than, prenatal services (see below for newly enrolled members receiving only prenatal services) the day before becoming a LaCare member, can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without prior authorization and without regard to whether such services are being provided by a participating or non-participating LaCare Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization (See Section IV: Referrals and Prior Authorization). LaCare will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the member may be reasonably transferred without disruption, whichever is less. LaCare will not deny authorization solely on the basis that the Practitioner/Provider is not a participating LaCare Practitioner/Provider.

Women in the first trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming a LaCare member, can continue to receive such medically necessary prenatal care services, including prenatal care, delivery, and postpartum care, without prior authorization and without regard to whether such services are being provided by a participating or non-participating LaCare Practitioner/Provider until such time as LaCare

can reasonably transfer the member to a participating LaCare Practitioner/Provider without impeding service delivery that might be harmful to the member's health.

Women in the second or third trimester of pregnancy and are receiving medically necessary covered prenatal care services the day before becoming a LaCare member can continue to receive services from their prenatal care Practitioner/Provider (whether a participating or non-participating LaCare Practitioner/Provider) through the postpartum period.

Newly Enrolled Members

Recipients receiving medically necessary covered services the day before becoming a LaCare member can continue to receive such medically necessary services for the first thirty (30) calendar days of enrollment, without prior authorization and without regard to whether such services are being provided by a participating or non-participating LaCare Practitioner/Provider. After thirty (30) calendar days, prior authorization requirements apply for those services identified as requiring prior authorization (See Section IV: Referrals and Prior Authorization). LaCare will continue to provide coverage for services determined to be medically necessary for an additional sixty (60) calendar days or until the member may be reasonably transferred without disruption, whichever is less. LaCare will not deny authorization solely on the basis that the Practitioner/Provider is not a participating LaCare Practitioner/Provider.

Current members receiving care from a Practitioner/Provider may continue an ongoing course of treatment (defined as treatment for a chronic or acute medical condition; behavioral health condition; or life-threatening illness) with a Practitioner/Provider whose contract is terminated with LaCare (either by LaCare or by the Practitioner) for up to ninety (90) calendar days from the effective date of the termination.

Current members who are in their second or third trimester of pregnancy or who are identified as having a high-risk pregnancy on the date that the member is notified by LaCare of the termination or pending termination, may continue an ongoing course of treatment with a non-participating Obstetrician (OB) or Midwife through the completion of post-partum care related to the delivery.

LaCare members receiving ongoing treatment, as outlined above, may not be billed for the costs of medically necessary core benefits and services.

Verifying Eligibility

Each network provider is responsible to ascertain a member's eligibility with LaCare before providing services.

Verification of eligibility consists of a few simple steps; they are:

- As a first step, all Providers should ask to see the member's LaCare Identification Card and the Louisiana Medicaid Card.
- It is important to note that LaCare ID cards are not dated and do not need to be returned to LaCare should the member lose eligibility. Therefore, a card itself does not indicate a person is currently enrolled with LaCare.

Since a card alone does not verify that a person is currently enrolled in LaCare, it is critical to verify eligibility through any of the following methods:

1. NaviNet - This free, easy to use web-based application provides real-time current and past eligibility status and eliminates the need for phone calls to LaCare. For more information or to sign up for access to NaviNet visit: https://navinet.navimedix.com/Main.asp
2. Louisiana Department of Health and Hospitals http://www.lamedicaid.com/provweb1/default.htm
3. **Louisiana Medicaid REVS Telephone Line**: **1-800-776-6323**. The 7-digit Louisiana Medicaid provider number must be entered to begin the eligibility verification process
4. LaCare's Automated Eligibility Hotline **888-922-0007**:

- Provides immediate real-time eligibility status with no holding to speak to a representative.
- Call the Automated Eligibility Hotline 24 hours/7 days a week, at **888-922-0007**:
- Verify a member's coverage with LaCare by their LaCare identification number, Social Security Number, name, birth date or Medicaid Identification Number
- Obtain the name and phone number of the member's PCP

Monthly Panel/Linkages List

Below is an example of the monthly LaCare pane/linkages list sent to PCP's. The monthly panel list is also available through www.navinet.net.

LaCare Health Plan Sample Panel List

1	2	3	4	5	6	7	8	9	10	11	12	13
Member ID#	Recipient#	DOB	Name	Address	Phone	Age	Gender	Other Ins	Date Eff On Panel	V*	Provider Name/No	N*
11111111	1010101010	5/2/2002	Abdul, Abba	123 Main Street New Orleans, LA 70112	504-999-9999	3m	M		5/2/2012		J Brown 11223344	Y
53333333	4030303030	2/1/1975	Abdul, Geraldine	321 My Street New Orleans, LA 70113	504-999-9999	27	F		2/1/2012		R Kelly 1156677	
37777777	6070707070	8/31/1986	Absent, Carol	555 Jazz St. New Orleans, LA 70146	504-999-9999	15	F		6/1/2012		B Jones 11777577	
84444444	7040404040	6/12/1990	Amber, Diane	1010 New Street New Orleans,	504-999-9999	49	M	Y	1/1/2012	Y	J Brown 1122334	

				LA 70125								
95555555	5050505050	10/5/1949	Bratt Esther	789 River St New Orleans, LA 70116	504-777-7777	61	F	Y	7/1/2012		B Smith 1122110	Y
50000000	6060606060	3/16/1967	Download, Darren	222 Good St New Orleans, LA 70122	504-222-2222	58	M		3/1/2012	Y	M Weinbert 1177558	
62000000	3060606060	4/21/1996	Candy, Frank	5678 Nice St New Orleans, LA 70170	504-444-4444	6	F		8/12/12		J Brown 11223344	Y

Panel Count = 7

1. LaCare Identification Number
2. Member's Assistance Recipient Number
3. Member's date of Birth
4. Member's Name
5. Member's Address
6. Member's Phone Number
7. Member's Age
8. Member's Gender
9. Member's Other Insurance
10. Member's Effective Date with PCP
11. V* = Was Member Seen Within Last 6 Months
12. Member's Assigned PCP
13. N* = New Member to PCP

Change in Recipient Coverage

The following addresses responsibility when there is a change in a recipient's coverage:

LaCare will provide active assistance to members transitioning to another CCN Plan or joining LaCare from another plan.

If a member transfers between CCN plans, the receiving CCN is responsible for the provision of medically necessary services that are required for the member during the transition period (i.e. prenatal care, acute care, etc.). The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN. During this transition period, the receiving CCN will notify the new PCP of member's selection initiate the request of transfer for the member's medical files, arrange medically necessary services (if applicable) and follow all other requirements for new members.

If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify the receiving CCN of the member's hospitalization status within five (5) business days of the beginning of the month that the new CCN member enrollment is effective.

Upon notification of the member's transfer, the receiving CCN will request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request. Other records such as case management files of the transitioning member must also be transmitted.

LaCare has a Transition Coordinator. This person shall interact closely with the DHH Medicaid Coordinated Care Section staff and staff from other CCNs to ensure a safe and orderly transition.

At the point of initial CCN implementation LaCare will ensure a smooth transition for members by not discontinuing a member's existing Louisiana Medicaid service plan for 30 days after the member transition unless mutually agreed to by the member or responsible party.

Members who transition from one CCN to another are considered newly enrolled with the receiving CCN. If LaCare is the receiving or relinquishing CCN, we will give special consideration to the following:

- Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;
- Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;

- Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;
- Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization;

When relinquishing members, LaCare will give timely information to the receiving CCN related to any special needs of transitioning members. LaCare, when receiving a transitioning member with special needs, will coordinate care with the relinquishing Contractor so services are not interrupted, will provide the new member with CCN and service information, emergency numbers and instructions on how to obtain services.

Nursing Facilities

LaCare is not responsible for payment of long term care (including hospital reserve or bed hold days) if a member is admitted to a Nursing Facility. LaCare is responsible for all core benefits and services until the member is disenrolled from LaCare. Members admitted to a facility/ nursing home for long term care will be disenrolled at the earliest effective date allowed by DHH systems.

LaCare Retroactive Eligibility

Occasionally, a CNN such as LaCare may be responsible for retroactive care. For example, LaCare, is responsible for a newborn from his/her date of birth when the mother is an active member with LaCare on the newborn's date of birth. A newborn will have the same managed care history as the mother from birth until added to the state computer database.

LaCare is not responsible for retroactive coverage for a member who lost eligibility but then regained it within the next six months. LaCare will commence coverage for the former member on the re-Enrollment date or the date the recipient is updated in the state computer data base, whichever is later.

> Example: A LaCare member loses eligibility on February 20, 2011. LaCare is responsible to continue coverage until the last calendar day of the month (February 28th). If the recipient is determined to be eligible June 2, 2011, for retroactive coverage back to April 10, 2011, and the computer database is updated on June 2, 2011, LaCare will resume responsibility for the member June 2, 2011.

Eligibility for Institutionalized Members

LaCare does not cover members residing in the following:

- Medical institution or Institution for Mental Disease (ICF/MR)
- Extended Acute Psychiatric Facilities, if applicable
- Home and Community Based Waiver Program Eligibles
- Nursing Home Residents with other Related Conditions (OSP/PBRA)
- Home and Community Based Waiver Program Eligibles for Attendant Care Services
- Community Based Services Waiver Program

Incarcerated Member Eligibility

LaCare is not responsible for any member who has been incarcerated in a penal facility, correctional institution (including work release), the member will be disenrolled from LaCare before placement in the institution.

Providers should contact LaCare Provider Services upon identification of any incarcerated member at **888-922-0007**.

Loss of Benefits

Members will lose their Medicaid health care coverage if:

- The member is no longer on Medicaid. (The member should have been notified in writing of lost eligibility. If the member's re-establishes eligibility in less than 60 days, the member will be automatically re-enrolled into LaCare.)
- They are incarcerated or they are placed in a juvenile detention center
- They commit Fraud or intentional misconduct and all appeals by the member have been exhausted
- The member moves out of Louisiana. The member must find out about Medicaid in the new state of residence

A member can be disenrolled from LaCare but not necessarily Medicaid eligibility if:

- Members who move from one GSA to another prior to full roll out of the CCN program will revert to the state fee for service program if LaCare is not operational in that GSA. Once the entire state is operating under the CCN program, members will be automatically re-enrolled into LaCare. The member will have ninety (90) calendar days from the effective date of re-enrollment with LaCare to request to change plans for any reason.
- The member becomes Medicare eligible
- The member is placed in the long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities)
- Member becomes a participant in a home and community-based services waiver;
- Member elects to receive hospice services

Plan Enrollment

Following their initial enrollment into LaCare, members have ninety (90) days from the postmark date of the Notice of Enrollment in which they may change CCNs for any reason. After the initial ninety (90) day period, members shall be locked into LaCare for nine (9) additional months for a total of twelve (12) months from the effective date of enrollment or unless disenrolled for cause.

LaCare does not lock members into a PCP, they may change PCPs at any time.

To disenroll from LaCare, the member must speak with an Enrollment Specialist by calling XXX-XXX-XXXX (**ENROLLMENT BROKER NUMBER).**

Voluntary Enrollees

Members in the following categories can voluntarily enroll in a CCN but are not mandated to be in the CCN program.

Children under 19 years of age who are:

- Eligible for SSI under title XVI;
- Eligible under section 1902(e)(3) of the Act;
- In foster care or other out-of-home placement;
- Receiving foster care or adoption assistance;
- Served by a family centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the DHH in terms of either program participation or special health care needs; or
- Enrolled in the Family Opportunity Act Medicaid Buy-In Program.
- Native Americans who are members of federally recognized tribes, except when the CNN is:
    - The Indian Health Service; or
    - An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

Following their initial enrollment into LaCare, voluntary members have ninety (90) days from the postmark date of the Notice of Enrollment in which they may change CCNs for any reason. After the initial ninety (90) day period, members shall be locked into LaCare for nine (9) additional months for a total of twelve (12) months from the effective date of enrollment.

Members in Voluntary categories will be advised of their option to opt out of mandatory managed care. Those who do not respond will be auto-assigned. Once auto assigned, these members will have the same 90 day change period and if they do not respond will be locked in for nine (9) months for a total of twelve (12) months from the date of enrollment.

Section III
Covered Benefits

Covered Benefits

LaCare members are entitled to all of the benefits provided under the Louisiana Medicaid Program.

NOTE: A Provider or member can ask LaCare to approve services above the inpatient hospitalization limits. An exception can be granted if a member has a serious chronic illness or other serious health condition and without the additional services their life and/or health would be in danger; would need more costly services if the exception is not granted; and/or would have to go into a nursing home or institution if the exception is not granted.

Benefits include, but are not necessarily limited to, the following:

- Ambulatory Surgical Services
- Ancillary Medical Services
- Audiology Services
- Basic Behavioral Health Services*
- Chemotherapy and Radiation Therapy
- Chiropractic Services for children
- Enhanced Dental for Adults**
- Diagnostic Services
- Durable Medical Equipment, Prosthetics, Orthotics and Certain Supplies
- KidMed/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- Emergency Medical Services
- Family Planning Services
- Home Health Care, including extended services for children
- Immunizations
- Inpatient Hospital Services
- Laboratory Services
- Medical Transportation – emergency and non-emergency
- Obstetrical/Gynecological Services
- Other specialty care services***
- Outpatient Hospital Services
- Primary Care Services
- Physical, Occupational, Respiratory and Speech Therapy
- Radiology services
- Rehabilitation Services
- Renal Dialysis
- Skilled Nursing Facility Services
- Vision/Eyewear Care for children
- Enhanced Vision Care for Adults****

* Contact LaCare for additional information. We cover basic behavioral services and link members and physicians (with member consent) with specialized behavioral services.

** Adults: One exam, one cleaning per year with no co-pay. Some Specialty Dental Services may require a referral. Additional Dental Care may not be covered for all members 21 years of age and older.

*** For members with a life-threatening, degenerative or disabling disease or condition, or members with other Special Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services Department at 888-922-0007.

**** Medical eye care provided for all members. Specialty Eye Care Services may require a referral. Optician and Eyewear Services are provided for children, Adults enhanced benefit provides one routine eye exam every 24 months, with a $10 copay. $40 allowance toward the purchase of eyeglasses (frame and lenses) every 24 months

Services Not Covered

Some services are not covered by the Louisiana Medicaid and/or LaCare, including, but not necessarily limited to, the following:

- Services that are not Medically Necessary
- Services rendered by a Health Care Provider who does not participate with LaCare, except for:
    - Medicare-covered services (see note at the end of the section titled Prior Authorization Requirements in Section II);
    - Emergency Services,
    - When otherwise prior authorized by LaCare.
- Elective cosmetic surgery, such as tummy tucks, nose reconstruction, face lifts and liposuction
- Services that require authorization by LaCare, but are not approved
- Experimental Treatment and investigational procedures, services and/or drugs
- Home Modifications (for example, chair lifts)
- Acupuncture
- Infertility Services
- Paternity Testing
- Any service offered and covered through another insurance program, such as Worker's Compensation, Medicare, TRICARE or other commercial insurance that has not been prior authorized by LaCare.
- Motorized Lifts for Vehicles
- Services provided outside the United States and its territories, with limited exceptions in Canada, Mexico and US Territorial Waters*
- Private duty (also known as shift care) skilled nursing and/or private duty home health aide services for members 21 years of age or older
- Services not considered a "medical service" under Title XIX of the Social Security Act

* When in doubt about whether LaCare will pay for health care services, please contact the Provider Services Department at 888-922-0007.

Co-Payment

The enhanced vision benefit for adults provides one routine eye exam every 24 months, with a $10 copay.

Section IV
Referral & Authorization Requirements

Referrals

Referrals are used to facilitate direction of the member to health care services appropriate to the member's needs and health status. Referral mechanisms include:

- Specialty Health care Referrals: The Primary Care Practitioner (PCP) issues referrals for specialty health care services for practitioners participating in the LaCare Network.
- Services for Women from an OB/GYN practitioner, plain x-ray films, electrocardiograms, EPSDT screening services, in-network eye care and vision services and services to treat an Emergency Medical Condition do not require a PCP referral or authorization from LaCare. (Except for services necessary to treat an Emergency Medical Condition, authorization from LaCare is required to obtain covered services from a practitioner or provider who does not participate with LaCare.)
- Standing Referrals: The PCP can issue a standing referral for members who need ongoing care from a specialist.
- Integrated Care Management Referrals: Any LaCare practitioner, provider, member or staff person can refer a member to one of LaCare's Integrated Care Management (ICM) programs. Specific programs exist for members with complex care needs and/or chronic conditions and for members who are pregnant.
- Medicaid State Plan Service Referrals: LaCare ICM staff coordinates referrals for members for services that are provided by the Louisiana fee-for-service Medicaid program.

Referrals Requirements

When a PCP determines the need for medical services or treatment, which will be provided outside the office, he/she must approve and/or arrange referrals to a participating Specialist,. Referrals are valid for 180 days with unlimited visits.

Services Requiring a Referral:

- Initial visits to a Specialist*

Services Not Requiring a Referral (Member Self Referral):

- Prenatal OB visits
- Routine OB/GYN visits
- Routine Family Planning Services. Members may go to any doctor or clinic of their choice to obtain Family Planning Services
- Routine Eye Exams **
- Prescription eyeglasses for members under 21 years of age
- The following Diagnostic Tests performed on an outpatient basis with a prescription from the PCP/Specialist- Routine Mammograms, Chest X-rays, Ultrasounds, Non-Stress Tests, Pulmonary Function Tests (Please refer to the Prior Authorization list in this section of the Manual for a list of radiological procedures that require Prior Authorization)
- Emergency Services including emergency transportation

* For members with a life-threatening, degenerative or disabling disease or condition, or members with other Special Needs, a standing referral may be available. For more

information on obtaining standing referrals, please contact the Provider Services Department at 888-922-0007.

** Some Specialty Eye Care Services may require a referral. See "Ophthalmology Services" in this Section in the Manual.

Referral Process

When a PCP determines the need for medical services or treatment, which occur outside the office, he/she must approve and/or arrange referrals to a participating Specialist. Referrals are valid for 180 days with unlimited visits.

The PCP should follow the steps outlined below prior to advising the member to access services outside of the office.

The PCP's office should:

- Verify member eligibility
- Determine if the needed service requires a referral or Prior Authorization from LaCare (See "Services Requiring Referrals and Prior Authorization" in this section of the Manual)
- Select a participating Specialist appropriate for the member's medical needs from the Specialist Directory, as appropriate. There is also an online network provider Directory with search capability at www.lacarelouisiana.com. (If an appropriate network provider is not listed in the network provider Directory please call Provider Services **888-922-0007** for assistance. See "**Out-of-Plan Referrals**" in this Section for additional information.)
- Specialists must follow the following appointment standards
    - Emergency appointments immediately upon referral
    - Urgent Care appointments within twenty-four (24) hours of referral
    - Routine appointments within one month of the referral

Once a network provider is selected, the referral process can be completed electronically or using the traditional paper process:

Generating electronic referrals through NaviNet

PCP offices use **Referral Submission** to submit referrals quickly and easily, and can look up referrals they submitted via **Referral Inquiry**. PCPs can print a copy of the referral for the chart and/or to give to the member

Specialists can use **Referral Inquiry** to view and retrieve referrals.

- Simply log on to NaviNet (https://navinet.net) and select LaCare Health Plan from Plan Central.
- Select Referral Submission or Referral Inquiry and follow the steps to refer a patient or view referrals
- To find specific instructions about these transactions, refer to the User Guides listed under Customer Service

If your office is not currently using NaviNet, you can enroll on-line at:
https://connect.navinet.net/enroll

Paper Referrals

- Issue a pre-numbered referral form for procedures requiring referrals.
- When issuing a referral form, make sure the form is legible and that all the required fields are completed. See the sample referral form in Appendix 6.
- The date of service must not be prior to the date the referral was requested.
- Mail yellow referral copies to:

  LaCare Health Plan
  Claims Processing Department
  PO Box 7322
  London, KY 40743

- Give a copy of the referral form to the member to present to the consulting Specialist.

Network providers may order supplies of the Referral Form and any other pre-printed LaCare supplied forms online in the Provider Center at www.lacelouisiana.com or by utilizing the Fax Request process. **A Supply Request Fax Form,** is Appendix 7 in this Manual. The form should be faxed to the toll-free number at **FAX LINE**. Fax orders received by 12 Noon on a regular business day will be filled and shipped that same day. Orders received after 12 Noon on a regular business day will be filled and shipped the next business day. If you experience any difficulty in faxing your order, or have any questions concerning your order, you may call the Warehouse Coordinator at **1-215-937-8800**.

Approval of Additional Procedures

Additional Procedures Performed in the PCP or Specialist Office or Outpatient Hospital/Facility Setting

When a Specialist or PCP determines that additional diagnostic or treatment procedures are required during an office visit, the Specialist must first determine if the procedures require further Prior Authorization. See "**Prior Authorization Requirements**" in this section of the Manual or, for most up-to-date information, please look online in the Provider Center at www.lacarelouisiana.com and click on the Provider Reference Guide.

If the procedure/treatment does require Prior Authorization, call the Utilization Management Department **888-913-0350** for Prior Authorization. It is not necessary that the Specialist or member re-contact the PCP office, however, the Specialist's office should inform the PCP of all diagnostic procedures, diagnostic tests and follow-up care prescribed for the member.

Additional Procedures Requiring Inpatient or SPU Admission

When the Specialist determines that additional medical or surgical procedures require an inpatient or Short Procedure Unit (SPU) admission, the Specialist must first determine if the procedures require further Prior Authorization. See "**Prior Authorization Requirements**" in this section of the Manual. When a procedure does require Prior Authorization, the Specialist should contact LaCare Utilization Management Department at **888-913-0350** to obtain Prior Authorization. The admission will be reviewed for medical necessity and a case reference number will be assigned. Pre-approval for medical/surgical admissions may be requested

directly by the attending specialist. It is not necessary that the Primary Care Practitioner (PCP) be contacted first, however, LaCare requires Specialists to maintain contact with the referring PCP regarding the member's status.

Follow-Up Specialty Office Visits

The initial referral given by the PCP is valid for 180 days, and for unlimited visits to the Specialists' office. If additional treatment is needed after the 180 day period, the Specialist should refer the member back to his PCP for another referral.

When the Specialist requires that the member be referred to another Specialist, either for evaluation and management or a diagnostic or treatment procedure, this visit must be approved by the member's PCP. Either the Specialist's office or the member should advise the PCP office of the need for the follow up services. The PCP office should then follow the referral process. See "**Referral Process**" in this section of the Manual.

Out-of-Plan Referrals

Occasionally, a member's needs cannot be provided through the LaCare Network. When the need for "out-of-plan" services arises, the network provider should contact the Utilization Management Department for Prior Authorizaton. The Utilization Management Department will make arrangements for the member to receive the necessary medical services with a Specialist of LaCare's choice in collaboration with the recommendations of the PCP. Every effort will be made to locate a Specialist within easy access to the member.

LaCare's Utilization Management Department Telephone Number is **888-913-0350**.

If a Non-Participating Provider is prior authorized, that provider must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained by calling Provider Services at **888-922-0007**. The out of network provider will be reimbursed at 90% of the Louisiana Medicaid Fee Schedule when LaCare can document three attempts to contract with the out-of-network provider.

Standing Referrals

For members with a life-threatening, degenerative or disabling disease or condition, or members with other Special Needs, a standing referral may be available. For more information on obtaining standing referrals, please contact the Provider Services Department at **888-922-0007**.

Referrals/Second Opinions

Second opinions, or consultations, may be requested by a member, the PCP, or LaCare itself. These services require a referral from the PCP. For more information, see the "**Referral Process**" in this section of this Manual for direction.

With respect to second opinion consultations, the following is highly recommended by LaCare:

- The selected consulting network provider should be in a practice other than that of the attending network provider
- The selected consulting network provider should possess a different tax identification number than the attending network provider

- The selected consulting network provider should possess a similar medical degree or medical specialty in order to provide an unbiased, but informed medical opinion on the condition for which the consultation is being requested

Prior Authorization Requirements

The most up to date listing of services requiring Prior Authorization can be found in the Provider Center at www.lacarelouisiana.com in the Provider Reference Guide or in posted updates.

Notification Required

- Maternity Obstetrical Services (after the first visit) and outpatient care (includes 30-Hour Observations)
- Normal newborn deliveries

Services Requiring Prior Authorization:

The following is a list of services requiring prior authorization review for medical necessity and place of service.

- In-patient services
  - All inpatient hospital admissions, including medical, surgical and rehabilitation
  - Obstetrical Admissions/Newborn Deliveries exceeding 48 hours after vaginal delivery and 96 hours after caesarean section
  - In-patient Medical Detoxification
  - Elective transfers for inpatient and/or outpatient services between acute care facilities
  - Long-Term Care Initial Placement if still enrolled with the plan
- Home-based services
  - Home Health Care (after 12 visits for therapies and 6 visits for skilled nurse visits)
  - Private Duty Nursing and Extended Home Health Services
  -
  - Private Duty Nursing (covered when medically necessary for under age 21)
  - Home Health Extended Services (for under age 21)
- Therapy and related services
  - Speech Therapy, Occupational Therapy and Physical Therapy (after 12 visits for each modality)
  - Chiropractic Care
  - Cardiac Rehabilitation
- Transplants, including transplant evaluations
- Injectable medications not listed on the Louisiana Medicaid Professional Services Fee Schedule are not covered by LaCare
- Air Ambulance
- Durable Medical Equipment. Prior Authorization is required for the following:
  - Items with billed charges $500 and over, including prosthetics and orthotics
  - All DME rentals

  - All Enteral Nutritional Supplements and Supplies
  - All Diapers/pull-up diapers for members ages 4 through 20 only. Not covered for members 21 and over and children under 3.
  - All Wheelchair parts
- Medications: 17-P and all infusion/injectable medications listed on the Louisiana Medicaid Professional Services Fee Schedule with billed amounts of $250 or greater;
- Surgical services that may be considered cosmetic, including
  - Blepharoplasty
  - Mastectomy for Gynecomastia
  - Mastoplexy
  - Maxillofacial
  - Panniculectomy
  - Penile Prosthesis
  - Plastic Surgery/Cosmetic Dermatology
  - Reduction Mammoplasty
  - Septoplasty
- Cochlear Implantation (covered for members under 21)
- Gastric Bypass/Vertical Band Gastroplasty
- Hysterectomy*
- Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks
- Radiology Services*
  - CT Scan
  - MRI
  - MRA
  - Nuclear Cardiac Imaging
- All unlisted and miscellaneous codes

* Prior Authorization for, CT Scans, MRIs/MRAs and Nuclear Cardiology services are required for outpatient services only. The ordering physician is responsible for obtaining a Prior Authorization number for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. (Outpatient studies ordered after normal business hours or on weekends should be conducted by the ordering facility as requested by the ordering physician. However, the ordering physician must contact UM within 48 hours or the next business day to obtain proper authorization for the studies, which will be subject to medical necessity review.) Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.

* Members seeking information on sterilization services, hysterectomies (for sterilization purposes) and abortions should call LaCare. Abortion and sterilization services require Prior Authorization by LaCare. A representative will make necessary arrangements for members eligible for these services. However, members seeking information on hysterectomies for medical reasons not related to sterilization may contact the **Member Services Department at 888-756-0004.**

Members with Medicare coverage may go to Medicare health care providers of choice for Medicare covered services, whether or not the Medicare Health Care Provider has complied with LaCare's Prior Authorization requirements. LaCare's policies and procedures must be followed for Non-Covered Medicare services.

Policies and Procedures

Medically Necessary

Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be:

- deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.

Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the member. All such determinations must be made by qualified and trained practitioners. Any decision to deny or reduce in amount, duration or scope a request for covered services will be made by clinical professionals who possess an active, unrestricted license and have the appropriate education, training, or professional experience in medical or clinical practice.

Alerts

Benefit Limits and Co-Payments

There may be benefit limits or co-payments associated with the services mentioned in this section. Please refer to the Benefits Grid located in Appendix 25 of this Manual or in the Provider Center at www.lacarelouisiana.com.

Authorization and Eligibility

Due to possible interruptions of a member's State Medicaid coverage, it is strongly recommended that Providers call for verification of a member's continued eligibility on the 1st of each month when a Prior Authorization extends beyond the calendar month in which it was issued. If the need for service extends beyond the initial authorized period, the Provider must call LaCare's Utilization Management Department to obtain Prior Authorization for continuation of service.

Ambulance – Transportation

LaCare is responsible to coordinate and reimburse for **Medically Necessary** transportation by ambulance for physical, psychiatric or behavioral health services.

Members experiencing a medical emergency are instructed to immediately contact their local emergency rescue service - 911

LaCare has contracted with specific transportation providers throughout the service area and will reimburse for Medically Necessary transportation services. For ambulance transportation to be considered Medically Necessary, one or more of the following conditions must exist:

- The member is incapacitated as the result of injury or illness and transportation by van, taxicab, public transportation or private vehicle is either physically impossible or would endanger the health of the member
- There is reason to suspect serious internal or head injury
- The member requires physical restraints
- The member requires oxygen or other life support treatment en route
- Because of the medical history of the member and present condition, there is reason to believe that oxygen or life support treatment is required en route
- The member is being transported to the nearest appropriate medical facility
- The member is being transported to or from an appropriate medical facility in connection with services that are covered under the MA Program
- The member requires transportation from a hospital to a non-hospital drug and alcohol detoxification facility or rehabilitation facility and the hospital has determined that the required services are not Medically Necessary in an inpatient facility

Ambulance - Non emergent Transportation- (NEMT)

Non emergency transportation is a ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations. LaCare will assist members in accessing non-ambulance transportation services for physical health appointments by linking them with MTM, our vendor for non-emergent Medical Transportation Members can access LaCare NEMT services by calling 888-913-0364. LaCare is financially responsible for payment for these services.

Non-emergency medical transportation to access carved out services (Specialized behavioral health care for example) is not the financial responsibility of LaCare and members should be

referred to the state non-emergency transportation programFor medically necessary non-emergent transportation requested by the member or someone on behalf of the member, LaCare requires our transportation provider to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; transportation home should not result in a wait more than one hour after the conclusion of the treatment; nor be picked up prior to the completion of treatment.

Ambulatory Surgical Centers

Free Standing: Reimbursement for surgical procedures performed in a Free Standing Ambulatory Surgical Center is a flat fee per service based on four payment groups established on the Medicaid fee schedule. Only one procedure code may be reimbursed per outpatient surgical session which will be the highest compensable service/code.

Hospital-Based/Outpatient ASC: Reimbursement for surgical procedures performed in a Free Standing Ambulatory Surgical Center is a flat fee per service based on four payment groups established on the Medicaid fee schedule. Only one procedure code may be reimbursed per outpatient surgical session which will be the highest compensable service/code. Revenue Code 490 must be billed for ASC services.

Behavioral Health Services

LaCare covers Basic Behavioral Health Services, which include:

- Screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (The EPSDT benefit guarantees coverage of "screening services" which must, at a minimum, include "a comprehensive health and developmental history – including assessment of both physical and mental health.) Section 1905(r)(1)(B)(i) of the Social Security Act, 42U.S.C. §1396d(r)(1)(B)(i));
- Behavioral health services provided in the member's PCP or medical office (CPT codes 99201-99215) or behavioral health services provided in a FQHC.
- Outpatient non-psychiatric hospital services based on medical necessity; and those behavioral health services for individuals whose need for such services is secondary to a primary medical condition in any given episode of care.

PCPs and other physical health care providers are required to screen for behavioral health care and often need to recommend that a member access specialized behavioral health services. The Health Care Provider or his/her staff can obtain assistance for members needing behavioral health services by calling the Behavioral Health MCO (RFP process currently underway- add numbers when known). In addition, LaCare will provide training on behavioral health care screenings. The times and dates will be announced online.

Cooperation between network providers and the Specialized Behavioral Service Providers is essential to assure members receive appropriate and effective care. Network providers are required to:

- Adhere to state and Federal confidentiality guidelines for mental health and drug and alcohol abuse
- Refer members to the appropriate Behavioral provider, once a mental health or drug and alcohol problem is suspected or diagnosed

- To the extent permitted by law, participate in the appropriate sharing of necessary clinical information with the Behavioral Health Provider including, if requested, all prescriptions the member is taking.
- Be available to the Behavioral Health Provider for consultation
- Participate in the coordination of care when appropriate
- Make referrals for social, vocational, educational and human services when a need is identified through an assessment
- Refer to the Behavioral Health Provider when it is necessary to prescribe a behavioral health drug, so that the member may receive appropriate support and services necessary to effectively treat the problem

The Specialized Behavioral Services Provider provides access to diagnostic, assessment, referral and treatment services including but not limited to:

- Inpatient and outpatient psychiatric services
- Inpatient and outpatient drug and alcohol services (detoxification and rehabilitation)
- EPSDT behavioral health rehabilitation services for members up to age 21

Health care providers may call LaCare's Member Services Department at **888-756-0004** whenever they need help referring a member for behavioral health services.

Dental Services

Dental Services are carved out of the covered services responsibilities for the CNNs with the exception of medical dental services. However, **Medically Necessary** dental treatment services for members are covered under LaCare's medical benefit when rendered in an inpatient, SPU or ASC setting, and when appropriately authorized by LaCare's Utilization Management Department.

LaCare also offers an expanded benefit for our adult members, which includes one dental exam and one dental cleaning per year. Medical and expanded services are handled through our dental vendor, DentaQuest at 1-800-508-6785.

LaCare PCPs will conduct initial EPSDT dental screenings and LaCare will assist in coordinating follow up care through the DHH dental network.

Durable Medical Equipment

Covered Services

LaCare members are eligible to receive Medically Necessary durable medical equipment (DME) needed for home use.

All DME purchases over $500, all DME rentals, and all wheelchairs (both rental and sale), wheelchair accessories and components, regardless of cost or member age must be Prior Authorized with the following exceptions:

Enteral Nutritional Supplements:

- Prior Authorization is required for members age 21 and over

- Prior Authorization is required when the request is in excess of $200/month for members under the age of 21
- If the Enteral Nutritional Supplements requested is the only source of nutrition for the member, the request is approved

Diapers/pull-up diapers:

- Any request in excess of 200 a month (for diapers or pull-up diapers or a combination of both) requires Prior Authorization
- Generic diapers/pull-up diapers must be dispensed
- Requests for brand specific diapers/pull-up diapers require Prior Authorization
- All diapers/pull-up diapers must be obtained at a LaCare participating DME provider. Members over the age of three (3) are eligible to obtain diapers/pull-up diapers when Medically Necessary. A written prescription from network provider is required

PCPs, Specialists and Hospital Discharge Planners are directed to contact LaCare's Utilization Management Department at **888-913-0350**. Because members may lose eligibility or switch plans, DME Providers are encouraged to access NaviNet for verification of the member's continued Medicaid eligibility and continued enrollment with LaCare when equipment is authorized for more than a one month period of time. Failure to do so could result in Claim denials.

Occasionally, members require equipment or supplies that are not traditionally included in the Medicaid Program. LaCare will reimburse participating DME network providers based on their documented invoice cost or the manufacturer's suggested retail price for DME and medical supplies not covered by the Louisiana Medicaid Program but covered under Title XIX of the Social Security Act, provided that the equipment or service is Medically Necessary and the network provider has received Prior Authorization from LaCare. In order to receive Prior Authorization, the requesting network provider can fax a letter of medical necessity to LaCare at **866-397-4522.**

The letter of medical necessity must contain the following information:

- Member's name
- Member's ID number
- The item being requested
- Expected duration of use
- A specific diagnosis and medical reason that necessitates use of the requested item.

Each request is reviewed by a LaCare Physician Advisor.

Occasionally, additional information is required and the network provider will be notified by LaCare of the need for such information. If you have questions regarding any DME item or supply, please contact the DME Unit at **888-913-0350** or the Provider Services Department at **888-922-0007**.

Elective Admissions and Elective Short Procedures

In order for LaCare to monitor quality of care and utilization of services, all Providers are required to obtain Prior Authorization from the Utilization Management Department **888-913-0350** for all non-emergency elective medical/surgical inpatient hospital admissions, as well as certain specific procedures performed in a SPU. See "Prior Authorization Requirements" earlier in this Section.

In order to qualify for payment, Prior Authorization is mandatory for designated procedures done in a SPU and elective inpatient cases

- LaCare will accept the hospital or the attending network provider's request for Prior Authorization of elective inpatient hospital and/or designated SPU admissions, however, neither party should assume the other has obtained Prior Authorization
- To prior authorize an elective inpatient or designated SPU procedure, practitioners are requested to submit via NaviNet, fax to **866-397-4522** or call to the Utilization Management Department at **888-913-0350**
- The Prior Authorization request will be approved when medical necessity is determined
- Procedures scheduled for the following calendar month can be reviewed for medical necessity; however, LaCare cannot verify the member's eligibility for the date of service. The network provider is required to re-verify eligibility though NaviNet.
- SPU procedures, which have been prior authorized for a particular date, may require rescheduling. The SPU authorizations are automatically assigned a fourteen (14) day window (the scheduled procedure date plus thirteen 13 days during which a SPU procedure can be rescheduled without notifying LaCare). Should the rescheduled date cross a calendar month, the network provider is responsible for verifying that the member is still eligible with LaCare before delivering care

Denied Prior Authorization requests may be appealed to the Medical Director or his/her designee. See "Provider Medical Necessity Appeal Procedures; Member Complaints, Grievances and Fair Hearings" in Section X of this Manual for information on how to file an appeal.

Emergency Admissions, Surgical Procedures and Observation Stays

Members often present to the ER with medical conditions of such severity, that further or continued treatment, services, and medical management is necessary. In such cases, the ER staff should provide stabilization and/or treatment services, assess the member's response to treatment and determine the need for continued care. To obtain payment for services delivered to members requiring admission to the inpatient setting, the hospital is required to notify LaCare of the admission and provide clinical information to establish medical necessity. Utilization Management assigns the most appropriate level of care based upon the clinical information provided, including history of injury or illness, treatment provided in the ER and patient's response to treatment, clinical findings of diagnostic tests, and interventions taken. An appropriate level of care, for an admission from the ER, may be any one of the following:

- ER Medical Care
- Emergency Surgical Procedure Unit (SPU) Service
- Emergent Observations Stay Services - Maternity & Other Medical/Surgical Conditions
- Emergency Inpatient Admission

- Emergency Medical Services

ER Medical Care

ER Medical Care is defined as an admission to the Emergency Department for an Emergency Medical Condition where short-term medical care and monitoring are necessary.

Emergency Medical Services

Emergency Room Policy

"An Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions (or)
- Serious dysfunction of any bodily organ or part

Prior Authorization/Notification for ER Services/Payment:

LaCare does not require Prior Authorization or prior notification of services rendered in the ER. ER staff should immediately screen all members presenting to the ER and provide appropriate stabilization and/or treatment services. Reimbursement for Emergency Services will be made at the contracted rate. LaCare reserves the right to request the emergency room medical record to verify the Emergency Services provided.

PCP Contact Prior to ER Visit

A member should present to the ER after contacting his/her PCP. Members are encouraged to contact their PCP to obtain medical advice or treatment options about conditions that may/may not require ER treatment. Should the PCP direct the member to the ER after telephone or office contact, the ER staff should screen members immediately upon arrival. Prior Authorization or prior notification of services rendered in the ER is not required.

Authorization of Inpatient Admission Following ER Medical Care

If a member is admitted as an inpatient following ER Medical Care, notification of to the Utilization Management Department is required through NaviNet, fax **866-397-4522** or phone call to **888-913-0350** for authorization. See Appendix 9 in the manual for the Notification of Emergent Hospital Admission form. The facility staff should be prepared to provide information to support the need for continued inpatient medical care beyond the initial stabilization period. The information should include treatment received in the ER; the response to treatment; result of post-treatment diagnostic tests; and the treatment plan. All ER charges are to be included on the inpatient billing form. Reimbursement for authorized admissions will be at the established contracted inpatient rate or state Medicaid fee schedule (if a non-network provider) with no separate payment for the ER Services. The inpatient case reference number should be noted on the bill.

Emergency SPU Services

Emergency SPU Services are when trauma, injury or the progression of a disease is such that a member requires:

- Immediate surgery, and
- Monitoring post surgery usually lasting less than twenty-four (24) hours, with
- Rapid discharge home, and
- Which cannot be performed in the ER

The ER staff should provide Medically Necessary services to stabilize the member and then initiate transfer to the SPU.

Authorization of Emergency SPU Services

Prior Authorization of an Emergency SPU service is not required. However, the hospital is responsible for notifying LaCare's Utilization Management Department within forty-eight (48) hours or by the next business day following the date of service for all Emergency SPU Services. Notification can be given either through NaviNet, or fax to **866-397-4522**, utilizing the Hospital Notification of Emergency Admissions Form (See the Appendix 9 of the Manual for the form). **Authorization of Inpatient Admission Following Emergency SPU Services.** Providers can also call 1-888-913-0350.

If a member is admitted as an inpatient following Emergency SPU Services, notification is required through NaviNet, or fax to **866-397-4522** or call to the Utilization Management Department at **888-913-0350** for authorization. The facility SPU staff should be prepared to provide additional information to support the need for continued medical care beyond 24 hours such as: procedure performed, any complications of surgery, and immediate post operative period vital signs, pain control, wound care etc. All ER and SPU charges are to be included on the inpatient billing form. Reimbursement will be at the established contracted inpatient rate or state Medicaid fee schedule (if a non network provider) with no separate payment for the ER and/or SPU services. The inpatient case reference number should be noted on the bill.

Emergent Observation Stay Services

LaCare considers Observation Care to be an outpatient service. Observation Care is often initiated as the result of a visit to an ER when continued monitoring or treatment is required.

Observation Care can be broken down into two categories:

- Maternity Observation, and
- Medical Observation (usually managed in the outpatient treatment setting)

Maternity/Obstetrical Observation Stay

A Maternity Observation Stay is defined as a stay usually requiring less than thirty (30) hours of care for the monitoring and treatment of patients with medical conditions related to pregnancy, including but not limited to:

- Symptoms of premature labor
- Abdominal pain
- Abdominal trauma

- Vaginal bleeding
- Diminished or absent fetal movement
- Premature rupture of membranes (PROM)
- Pregnancy induced hypertension/Preeclampsia
- Hyperemesis
- Gestational Diabetes

Members presenting to the ER with medical conditions related to pregnancy should be referred, whether the medical condition related to the pregnancy is an emergency or non-emergency, to the Labor and Delivery Unit (L & D Unit) for evaluation and observation. **Authorization is not required for Maternity/Obstetrical Observation at participating facilities. These services should be billed with Revenue Codes 720 – 729.**

ER Medical Care rendered to a pregnant member that is unrelated to the pregnancy should be billed as an ER visit, regardless of the setting where the treatment was rendered, i.e., ER, Labor & Delivery Unit or Observation. See "Claims Filing Instructions" in Section V of the Manual for Claim submission procedures.

Authorization of Inpatient Admission Following OB Observation

If a member is admitted after being observed, notification is required to the Utilization Management Department through NaviNet, or by Fax, or by calling **888-913-0350** for authorization. If the hospital does not have an L&D Unit, the hospital ER staff will include in their medical screening a determination of the appropriateness of treating the member at the hospital versus the need to transfer to another facility that has an L&D Unit, as well as Level II (Level III preferred) nursery capability. For members who are medically stable for transfer and who are not imminent for delivery, transfers are to be made to the nearest LaCare participating hospital. Hospitals where members are transferred should have an L&D Unit, Perinatology availability, as well as Level II (Level III preferred) nursery capability. In situations where the presenting hospital does not have an L&D Unit and transfer needs to occur after normal business hours or on a weekend, the hospital staff should facilitate the transfer and notify LaCare's Patient Care Management Department via NaviNet, a phone call or fax the first business day following the transfer.

A case reference number will be issued for the inpatient stay, which conforms to the protocols of this policy and member eligibility. All ER and Observation Care charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or actual billed charges, whichever is less, with no separate payment for the ER and/or Observation Stay Services. The inpatient case reference number should be noted on all Claims related to the inpatient stay.

Lack of timely notification may result in a Denial of Services. For information on appeal rights, please see "Claims Disputes and Provider Complaint Procedures in Section V of the Manual.

Medical Observation Stay

A Medical Observation Stay is defined as a stay requiring less than thirty (30) hours of care for the observation of patients with medical conditions including but not limited to:

- Head Trauma
- Chest Pain
- Post trauma/accidents
- Sickle Cell disease
- Asthma
- Abdominal Pain
- Seizure
- Anemia
- Syncope
- Pneumonia

Members presenting to the ER with Emergency Medical Conditions should receive a medical screening examination to determine the extent of treatment required to stabilize the condition. The ER staff must determine if the member's condition has stabilized enough to warrant a discharge or whether it is medically appropriate to transfer to an "observation" or other "holding" area of the hospital, as opposed to remaining in the ER setting. **Authorization is not required for a Medical Observation Stay at participating facilities.**

Authorization of Inpatient Admission Following Medical Observation

If a member is admitted as an inpatient following a Medical Observation Stay, notification is required to the Utilization Management Department through NaviNet, by Fax to 866-397-4522 or by calling **888-913-0350** for authorization. Hospital ER or Observation unit staff should include in their medical screening a determination of the appropriateness of treating the member as an inpatient versus retention in the Observation Care setting of the facility. If the member is admitted as an inpatient, all ER and Observation charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate or state Medicaid fee schedule (if a non participating hospital), with no separate payment for the ER and/or Observation Stay Services. The inpatient care case reference number should be noted on all Claims related to the inpatient stay.

Observation Billing Guidelines can be found in Appendix 8 in the manual.

Emergency Inpatient Admissions

Emergency Admissions from the ER, SPU or Observation Area

If a member is **admitted** after being treated in an Observation, SPU or ER setting of the hospital, the hospital is responsible for notifying LaCare's Utilization Management Department **within forty-eight (48) hours** or by the **next business day** (whichever is later) following the date of service (admission). Notification can be given either through NaviNet, by Fax to UM FAX 866-397-4522 or phone to **888-913-0350** utilizing the **Hospital Notification of Emergency Admissions form** (see Appendix 9 of the Manual for a copy of the form; the form can also be found in the Provider Forms section on www.lacarelouisiana.com. The Observation, SPU or ER charges should be included on the inpatient billing. Reimbursement will be at the established contracted inpatient rate with no separate payment for the Observation, SPU or ER services. The inpatient case reference number should be noted on the bill.

Emergency Services Provided by Non-Participating Providers

LaCare will reimburse health care providers who are not enrolled with LaCare when they provide Emergency Services for a LaCare member. The Health Care Provider, however, must obtain a Non-Participating Provider number in order to be reimbursed for services provided. The form for obtaining a Non-Participating Provider number can be obtained on www.lacarelouisiana.com or by calling Provider Services at **888-922-0007**.

Non-Participating Providers can find the complete Non-Participating Emergency Services Payment Guidelines as Appendix 23 in the on-line Provider & Practitioner Manual in the Provider Center of www.lacarelouisiana.com.

Please note that applying for and receiving a Non-Participating Provider number after the provision of Emergency Services is for reimbursement purposes only. It does not create a participating provider relationship with LaCare and does not replace provider enrollment and credentialing activities with LaCare (or any other health care plan) for new and existing network providers.

Family Planning

Members are covered for family planning services without a referral or Prior Authorization from LaCare.

Hysterectomies, Abortion or sterilization services are NOT considered family planning. These procedures require Prior Authorization from LaCare and the completion of additional approval steps, as outlined below:

Hysterectomies

Non-elective, Medically Necessary hysterectomies are covered by LaCare if the following requirements are met:

- The individual or her representative, if any, must sign and date the **Acknowledgment of Receipt of Hysterectomy Information** form (See Appendix 10 in the manual) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
- The **Acknowledgment of Receipt of Hysterectomy Information** form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
- The **Acknowledgment of Receipt of Hysterectomy Information** form is not required if the individual was already sterile before the hysterectomy or if the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.
- Hysterectomy is not covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.
- Hysterectomy is not be covered if there was more than one purpose for performing the hysterectomy, but the **primary** purpose was to render the individual permanently incapable of reproducing.

Sterilization

Sterilization is defined as any medical treatment or procedure that renders an individual permanently incapable of reproducing. Federal regulations contained in 42 CFR §§441.250 - 441.259 require that a consent form be completed before a sterilization procedure can be performed. Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing. The individual seeking sterilization must voluntarily give informed consent on the approved **Sterilization Consent Form** (See Appendix 11 in the manual) which will satisfy federal and state regulations. The informed consent must meet the following conditions:

- The individual to be sterilized must give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.
- The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affects the patient's state of awareness.
- The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.
- The individual to be sterilized is mentally competent.
- The individual to be sterilized is not institutionalized: *i.e.*, not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.

Abortion

Coverage of abortions is limited to two circumstances:

1. A woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed; or
2. The pregnancy is the result of an act of rape or incest.

In the first circumstance, a physician must certify in their handwriting, that on the basis of their professional judgment, the life of the pregnant woman would be endangered if the fetus were carried to term. The provider must attach the certification statement to the claim form that shall be retained by the LaCare. The certification statement shall contain the name and address of the patient. The diagnosis or medical condition which makes the pregnancy life endangering shall be specified on the claim.

In the case of terminating a pregnancy as the result of an act of rape or incest the following requirements shall be met:

- The member shall report the act of rape or incest to a law enforcement official unless the treating physician certifies in writing that in the physician's professional opinion, the victim was too physically or psychologically incapacitated to report the rape or incest;

- The report of the act of rape or incest to law enforcement official or the treating physician's statement that the victim was too physically or psychologically incapacitated to report the rape or incest shall be submitted to LaCare along with the treating physician's claim for reimbursement for performing an abortion;
- The member shall certify that the pregnancy is the result of rape or incest and this certification shall be witnessed by the treating physician; and
- The **Certification of Informed Consent - Abortion**, which must be obtained from the Louisiana Office of Public Health (Appendix 12 in the manual) shall be witnessed by the treating physician. Providers shall attach a copy of the **Certification of Informed Consent -Abortion** form to their claim form. All claim forms and attachments will be retained by LaCare**.**

Home Health Care

LaCare encourages home health care as an alternative to hospitalization when medically appropriate. Home health care services are recommended:

- To allow an earlier discharge from the hospital
- To avoid unnecessary admissions of members who could effectively be treated at home
- To allow members to receive care in greater comfort, because they are in familiar surroundings

Home Health Care should be utilized for the following types of services:

- Skilled Nursing
- Infusion Services
- Physical Therapy
- Speech Therapy
- Occupational Therapy

LaCare's **Utilization Management Department** will coordinate Medically Necessary home health and home infusion needs with the PCP, attending specialist, hospital home care departments and other providers of home care services. Contact LaCare's **Utilization Management Department** through NaviNet or Fax to 866-397-4522 or call **888-913-0350** to obtain an authorization.

Due to possible interruptions of the member's State Medicaid coverage, it is strongly recommended that Providers call for verification of the member's continued eligibility the 1st of each month. If the need for service extends beyond the initial authorized period, the Provider must re-verify eligibility through Navinet.

Hospice Care

Hospice Care is a carved out service and is covered by DHH. LaCare will assist in coordinating service for members in need of this service. Please call our Rapid Response Unit at 888-643-0005.

Hospital Transfer Policy

When a member presents to the ER of a hospital ***not participating*** with LaCare ***and the member requires admission to a hospital***, LaCare may require that the member be stabilized and transferred to a LaCare participating hospital *for* ***admission.*** When the medical condition of the member requires admission for stabilization, the member may be admitted, stabilized and then transferred within twenty-four (24) hours of stabilization to the closest LaCare participating facility.

Elective inter-facility transfers must be prior authorized by LaCare's Utilization Management Department at 888-913-0350.

These steps must be followed by the Health Care Provider:

- Complete the authorization process
- Approve the transfer
- Determine prospective length of stay
- Provide clinical information about the patient

Either the sending or receiving facility may initiate the Prior Authorization, however, the original admitting facility will be able to provide the most accurate clinical information. Although not mandated, if a transfer request is made by a LaCare participating facility, the receiving facility may request the transferring facility obtain the Prior Authorization before the case will be accepted. When the original admitting facility has obtained the Prior Authorization, the receiving facility should contact LaCare to confirm the authorization, obtain the case reference number and provide the name of the attending Health Care Provider.

In emergency cases, notification of the transfer admission is required within forty-eight (48) hours or by the next business day (whichever is later) by the receiving hospital. Lack of timely notification may result in a denial of service.

Within 24 hours of notification of inpatient stay, the hospital must provide a comprehensive clinical review, initial assessment and plans for discharge.

Medical Supplies

Certain medical supplies are available with a valid prescription through LaCare's medical benefit, and are provided through participating pharmacies and durable medical equipment (DME) suppliers. Such as:

- Vaporizers (one per calendar year)
- Humidifiers (one per calendar year)
- Diapers/Pull-Up Diapers may be obtained as follows:
    - Members over the age of three (3) are eligible to obtain diapers/pull-up diapers when Medically Necessary
    - A written prescription from participating practitioner is required
    - The quantity limit is 200 diapers/pull-up diapers (pediatric and adult) per month
    - Generic diapers/pull-up diapers must be dispensed
    - Brand diapers/pull-up diapers require Prior Authorization

  - Prior Authorization must be obtained for quantities greater than 200 diapers/pull-up diapers per month, or for diapers/pull-up diapers to be supplied by a DME network provider by calling **888-913-0350**
- Blood pressure monitors are covered by LaCare with a prescription. Coverage is currently limited to one (1) unit per 365 days.

Newborn Care

LaCare assumes financial responsibility for services provided to newborns of mothers who are active members. However, these newborns are not automatically enrolled in LaCare at birth. The CCN shall contact members who are expectant mothers sixty (60) calendar days prior to the expected date of delivery to encourage the mother to choose a CCN and a PCP for her newborn.

Hospitals must report the births of newborns within twenty-four (24) hours of birth for enrolled members using DHH's web-based **Request for Newborn Manual** system. (See Appendix 13 in the manual). If the mother has made a CCN and/or PCP selection, this information shall be reported. If no selection is made, the newborn will be automatically enrolled in the mother's CCN. Enrollment of newborns shall be retroactive to the date of the birth.

Hospitals must also register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry. LEERS information and training materials are available at:

http://www.dhh.louisiana.gov/offices/page.asp?id=252&detail=9535

Health Care Provider charges for circumcision and inpatient newborn care must be billed under the newborn's LaCare ID number

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) screens must be completed on every newborn, and submitted to LaCare's Claims Processing Department. Please refer to the Pediatric Preventative Health Care Program in this section of the manual for EPSDT instructions.

Detained Newborns and Other Newborn Admissions

LaCare requests notification on all newborns.

- LaCare regards a baby **detained** after the mother's discharge as a new admission requiring separate authorization. The admission must be reported to LaCare's Utilization Management Department and a new case reference number will be issued for the detained baby. Reimbursement for the higher level of care for the baby will revert to the day the baby is admitted to the higher level of care, based on meeting criteria.
- Facilities are required to notify LaCare of all admissions to an **Intensive Care** or **Transitional Nursery** within 24 hours of the admission (even if the admission does not result in the baby being detained).
- Facilities are also required to notify LaCare of all newborn admissions where the payment under their contract will be at other than the newborn rate (even if the baby is not detained or admitted to an Intensive Care or Transitional Nursery).

Facilities should report through NaviNet, or Fax to 866-397-4522 or call the Utilization Management Department at **888-913-0350** and follow prompts. When reporting a detained baby or other newborn admission notifications, please be prepared to leave the following information:

- Mother's first and last name
- Mother's LaCare ID #
- Baby's first and last name
- Baby's date of birth (DOB)
- Baby's sex
- Admission date to Intensive Care/Transitional Nursery
- Baby's diagnosis
- First and last name of baby's attending practitioner
- Facility name and LaCare ID #
- Caller's name and complete phone number

Upon review, a Utilization Management Coordinator will contact the facility and provide the authorization number assigned for the baby's extended stay or other admission. **All facility and associated practitioner charges should be billed referencing this authorization number.**

LaCare will pay detained newborn or other newborn admission charges according to established hospital-contracted rates for the bed-type assigned (e.g., NICU) commencing with the day the mother is discharged from the hospital. A new admission with a new case reference number will be assigned for the detained newborn or newborn admitted for other reasons. All detained baby or other newborn admission charges must be billed on a separate invoice.

LaCare Nurse Call Line – 1-888-632-0009

For LaCare Members, support is just a phone call away. We encourage members to call their PCP first, before they call the Nurse Call Line. But – when members cannot reach your office, and when the LaCare Care Coordination Department is closed, registered nurses are available to assist your patients.

The staff at the LaCare Nurse Call Line provides answers to health questions that are easy to understand. Patients can call toll-free and talk with a registered nurse or listen to health topics any time of the day or night.

The nurses may help your patients:

- Address symptoms they are having and provide direction to seek appropriate care.
- Decide if there is an emergency and if they need to go to the emergency room (ER).
- Learn about health and medical concerns so they can discuss them with you.
- Learn about the medicines they are taking.
- Pick the best exercises and foods for a healthy lifestyle.
- Address questions and learn about medical tests and procedures.
- Enhance their understanding of specific medical problems like diabetes or asthma.

All calls to the Nurse Call Line are recorded for quality purposes. A triage/encounter report on each call is provided to LaCare on a daily basis. These reports are reviewed by the Care

Coordination Team. Members receive a follow-up call to discuss the outcome of the call and determine if there has been a change in their health status and/or to determine if assistance is needed. Patients are also encouraged to seek care from their PCP and are offered assistance with scheduling appointments and arranging transportation services.

The assigned PCP will also receive a faxed copy of the member triage report for their files.

Nursing Facility

Covered Services

If a member needs to be referred to a Nursing Facility, the PCP should contact LaCare's Utilization Management Department. LaCare will coordinate necessary arrangements between the PCP, the referring facility, and the Nursing Facility in order to provide the needed care. Reimbursement for long term care placement in a Nursing Facility is covered by DHH. LaCare covers placement in a Nursing Facility for rehabilitation, skilled nursing or short term need for nursing facility services..

Obstetrical/Gynecological Services

Direct Access

Female members may self refer to a participating general OB/GYN provider for routine OB/GYN visits. A referral from the member's PCP is not required.

WeeCare Maternity Management

LaCare offers a perinatal Case Management program, called WeeCare, to pregnant members. More information about this program can be found in Section VIII, Special Needs/Case Management.

The goal of the program is to reduce infant morbidity and mortality among members. WeeCare is comprised of nurses, social workers, and administrative staff who actively seek to identify pregnant members as early as possible in their pregnancy, and continue to follow them through time of delivery.

Obstetrician's Role In WeeCare

OB network providers play a very important role in the success of the WeeCare Program, particularly the early identification of pregnant members to the WeeCare Program. OB network providers are responsible for the following:

- Following the American College of Obstetricians and Gynecologists (ACOG) standards of care for prenatal visits and testing
- Complying with LaCare protocols related to referrals and, Prior Authorization

Completing Obstetrical Needs Assessment Form (ONAF) (located in Appendix 14 in the manual and online in the Provider Forms Section at www.lacarelouisiana.com and return within 48 hours of the initial prenatal visit by faxing to the WeeCare **Fax:** 1-888-877-5925

Or mail to

Mail: LaCare Health Plan
PO Box 83580
Baton Rouge, LA 70884

- Use the ONAF form to document the date of the initial prenatal visit. Please contact the WeeCare Department at **888-913-0327** to report updates and subsequent visits.
- Complete the section of the ONAF form that needs to be returned to WeeCare by fax to **888-877-5925** or mail to address above after the postpartum visit.

OB network providers are required to cooperate with inquiries from WeeCare staff and inform us about their LaCare members. For further information on the WeeCare program, please contact the WeeCare Department at **888-913-0327**.

OB network providers are encouraged to refer smoking mothers for smoking cessation services. Refer members to the following resources:

- Tobacco Cessation Helpline – 1-800-QUIT-NOW
- Tobacco Smoking Cessation Hotline – 1-800-LUNG-USA
- Freedom From Smoking Clinics – 1-800-LUNG-USA
- Freedom from Smoking Online – www.ffsonline.org

Ophthalmology Services

Non-Routine Eye Care Services

When a member requires **non-routine** eye care services resulting from accidental injury or trauma to the eye(s), or treatment of eye diseases, LaCare will pay for such services through the medical benefit. The PCP should initiate appropriate referrals and/or authorizations for all non-routine eye care services.

See "**Vision Care**" in this section of this Manual for a description of LaCare's Routine eye care services. LaCare's routine eye care services for children under 21 and enhanced benefit for adults are administered through Vision vendor. Covered Routine eye exams and corrective lens Claims should not be submitted to LaCare for processing.

Questions concerning benefits available for Ophthalmology Services should be directed to the Provider Services Department at **888-922-0007**.

Outpatient Laboratory Services

In an effort to provide high quality laboratory services in a managed care environment for our members, LaCare has made the following arrangements:

- LaCare encourages network providers to perform venipuncture in their office. Providers should then contact laboratory provider to arrange pick-up service
- Providers with CLIA Certification, or a waiver of a certificate of registration along with a CLIA identification number, may perform approved labs in their offices and be reimbursed for those lab services

- Except for STAT laboratory services, LaCare requires that network providers utilize a network laboratory (unless the provider has CLIA certification) when outpatient laboratory studies are required for their LaCare members.

STAT laboratory services are defined as laboratory services that require completion and reporting of results within four (4) hours of receipt of the specimen. A representative listing of STAT tests and their accompanying procedure codes is found in Appendix 16of the Manual.

The PCP is responsible for including all demographic information when submitting laboratory testing request forms.

Outpatient Renal Dialysis

LaCare does not require a referral or Prior Authorization for Renal Dialysis services rendered at Freestanding or Hospital-Based outpatient dialysis facilities.

Free-Standing Facilities

The following services are payable without Prior Authorization or referrals for Free-Standing facilities:

- Training for Home Dialysis
- Back-up Dialysis Treatment
- Hemodialysis - In Center
- Home Rx for CAPD Dialysis (per day)
- Home Rx for CCPD Dialysis (per day)
- Home Treatment Hemodialysis (IPD)

Hospital Based Outpatient Dialysis

LaCare will reimburse Hospital Based Outpatient Dialysis facilities for all of the above services including certain lab tests and diagnostic studies that, according to Medicare guidelines, are billable above the Medicare composite rate. Please refer to Medicare Billing Guidelines for billable End Stage Renal Disease tests and diagnostic studies.

Associated provider services (Nephrologist or other Specialist) require a referral that must be initiated by the PCP. Once the treatment plan has been authorized, the PCP may request a standing referral by contacting LaCare through NaviNet or contacting the Provider Services Department at **888-922-0007.**

The following services require Prior Authorization through LaCare's Utilization Management Department:

- Supplies and equipment for home dialysis patients (Method II)
- Home care support services provided by an RN or LPN
- Transplants and transplant evaluations
- All inpatient dialysis procedures and services

Outpatient Testing

When a Specialist determines that additional diagnostic or treatment procedures are required during an office visit, which has been previously authorized by the member's PCP with the initial referral form, there is no further referral required.

Referrals are valid for 180 days from the date of issue, for unlimited visits to the Specialist's office.

When a diagnostic test or treatment procedure not requiring Prior Authorization will be performed in an Outpatient Hospital/Facility, the specialist should note the member's information and procedures to be performed on his/her office prescription form. Refer to "**Prior Authorization Requirements**" section of the Manual for a complete list of procedures requiring Prior Authorization.

When a patient presents to the hospital for any outpatient services not requiring a referral or Prior Authorization, he/she must bring a copy of the ordering Health Care Provider's prescription form.

Outpatient Therapies

Physical, Occupational, and Speech

Members are entitled to 12 physical, 12 occupational, and 12 speech therapy outpatient visits within a calendar year. A referral from the member's PCP is required for the initial visit to the therapist. Initial visits are not considered part of the 12 visits.

Once the member exceeds the 12 visits of any modality, physical, occupational, and/or speech therapy, an authorization is required to continue services. The therapist must contact LaCare's Utilization Management Department through NaviNet, fax to **866-397-4522** or call **888-913-0350** to obtain an authorization.

Pediatric Preventive Health Care Program

Liasions in the EPSDT Department, working with the LaCare EPSDT Coordinator assist the Parents or Guardians of all members younger than twenty-one (21) years of age in receiving EPSDT screens, treatment, follow-up, and referrals to the Early Intervention Program when appropriate. The EPSDT liaison also facilitates and ensures EPSDT compliance, provides follow-up concerning service issues, educates non-compliant members on LaCare's rules and regulations, and assists members in accessing care.

The quantity of Medically Necessary, Title XIX eligible services for enrolled children younger than twenty-one (21) years of age are not restricted or limited.

KIDMED/EPSDT Screens

Under EPSDT, State Medicaid agencies must provide and/or arrange for the promotion of services to eligible children younger than twenty-one (21) years of age that include

comprehensive, periodic preventive health assessments. All Medically Necessary immunizations are required. Age appropriate assessments, known as "screens," must be provided at intervals following defined periodicity schedules. Additional examinations are also required whenever a health care provider suspects the child may have a health problem. Treatment for all Medically Necessary services discovered during an EPSDT screening is also covered.

EPSDT Screens must include the following:

- A comprehensive health and developmental history, including both physical and mental health development
- A comprehensive unclothed exam
- Appropriate immunizations according to age and health history
- Appropriate laboratory tests including blood lead level assessment
- Health education including anticipatory guidance

EPSDT Covered Services

The following services are covered under the EPSDT Program:

- Comprehensive screens according to a predetermined periodicity schedule (found in the Provider Center at www.lacarelouisiana.com):
    - Children ages birth through 30 months should have screening visits at the following intervals: by 1 month, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months
    - Children and adolescents ages 3 years to 21 years of age are eligible for annual screens.
- After completion of a screen, members are entitled to all services included in the approved Medicaid State Plan for diagnosing and treating a discovered condition. Such services may include:
    - Eye Care
    - Hearing Care, including hearing aids
    - Dental Care (referral to dentist for dental screening is required annually for all children aged 3 years and older as part of a complete EPSDT screen)

In addition, LaCare will pay for routine health assessments, diagnostic procedures, and treatment services provided by network providers and clinics, as well as vision and hearing services, and dental care, including orthodontics.

LaCare complies with the relevant OBRA provisions regarding EPSDT by implementing the following:

- Health education is a required component of each screening service. Health education and counseling to parent (or guardian) and children is designed to assist in understanding what to expect in terms of the child's physical and cognitive development. It is also designed to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention
- Screening services are covered at intervals recommended by the Academy of Pediatrics and the American Dental Association. An initial screening examination may be requested at any time, without regard to whether the member's age coincides with the established periodicity schedule

- Payment will be made for Medically Necessary diagnostic or treatment services needed to correct or ameliorate illnesses or conditions discovered by the screening services, whether or not such diagnostic or treatment services are covered under the State Medicaid Plan and ***provided that it*** is covered under Title XIX of the Social Security Act. However, network providers should be aware that any such service must be prior-authorized and that a letter of medical necessity is required

EPSDT Expanded Services

EPSDT Expanded Services are defined as any Medically Necessary health care services provided to a Medicaid recipient younger than twenty-one (21) years of age that are covered by the federal Medicaid Program (Title XIX of the Social Security Act), but not currently recognized in the State's Medicaid Program. These services, which are required to treat conditions detected during an encounter with a health care professional, are eligible for payment under the Federal Medicaid Program, but are not currently included under the state's approved Medicaid Plan. EPSDT Expanded Services may include items such as medical supplies or Enteral formula or brand name diapers, for example. Additional information on EPSDT Screening Requirements is located in the later portion of this section.

Eligibility for EPSDT Expanded Services

All members younger than twenty-one (21) years of age are also eligible for EPSDT Expanded Services, when such services are determined to be Medically Necessary. There is no limitation on the length of approval for services, as long as the conditions for medical necessity continue to be met and the member remains eligible for LaCare benefits.

EPSDT Expanded Services Requiring Prior Authorization

EPSDT Expanded Services require Prior Authorization. All requests for EPSDT Expanded Services should be forwarded to LaCare's Utilization Management Department where they will be reviewed for medical necessity. Requests should be accompanied by a letter of medical necessity outlining the rationale for the request and the benefit that the requested service(s) will yield for the member. Although Utilization Management will accept letters of medical necessity from a member's PCP, a participating Specialist or Ancillary Health Care Provider, the PCP will be asked to approve the treatment plan. The Utilization Management phone number is 1-888-913-0350.

Obtaining PCP Approval for EPSDT Expanded Services

When a request for EPSDT Expanded Services and letter of medical necessity are received without prior approval from the PCP, Utilization Management will contact the PCP to obtain his/her approval. If Utilization Management is unsuccessful after one week of repeated attempts to reach the PCP, the author of the letter of medical necessity will be verbally informed of LaCare's inability to reach the PCP. The author will be asked to intervene by reaching the PCP to discuss the request. When the PCP is contacted but does not approve the request, he/she will be asked to contact the requesting network provider to discuss the case and offer alternatives.

EPSDT Expanded Services Approval Process

When the LaCare Medical Director or his/her designee approves a request for EPSDT Expanded Services, the requesting network provider will be asked to identify a network provider for the service if this was not already done. The provider of service should contact LaCare's Utilization Management Department for a case reference number. The provider of service will be responsible for conducting Concurrent Reviews with LaCare's Utilization Management Department to obtain authorization to extend the approval of services. The provider of service is also responsible for verifying the member's eligibility prior to each date of service.

EPSDT Expanded Services Denial Process

Prior to denying any request, the LaCare Medical Director or his/her designee will make several attempts, as an effort of good faith, to contact the requesting network provider to discuss the case. If the request is denied in full or in part, a letter, issued within 14 days of the decision,detailing the rationale for the decision will be sent to the member, the requesting network provider, and if identified, the provider of service or advocate working on the behalf of the member. This letter will also contain information regarding how the decision can be appealed and for members, information on how to contact community legal service agencies who might be able to assist in filing the Grievance.

LaCare will honor EPSDT Expanded Service treatment plans that were approved by another Medicaid Managed Care Organization or The State, prior to the member's enrollment with LaCare. The Health Care Provider of service is responsible for forwarding documentation of the prior approval in order for LaCare to continue to authorize previously approved services. LaCare will not interrupt services pending a determination of medical necessity in situations where the Health Care Provider is unable to document the approval of services by the previous insurer.

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens may bill using the CMS 1500 or UB-04 paper claim forms or electronically, using the 837 format.

Providers choosing to bill for complete EPSDT screens, including immunizations, on the CMS 1500 or UB-04 claim form or the 837 electronic formats must:

- Use V20.0, V20.1 or V20.2 as the primary diagnosis code
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.
- Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; 90 - Outpatient Lab; U1 - Autism.
    - Use U1 modifier in conjunction with CPT code 96110 for Autism screening

- CPT code 96110 without a U1 modifier is to be used for a Developmental screening

Age Appropriate Evaluation and Management Codes

(As listed on the current EPSDT Periodicity Schedule and Coding Matrix)

Newborn Care:

99460 Newborn Care (during the admission) 99463 Newborn (same day discharge)

New Patient:	**Established Patient:**
99381 Age < 1 yr	99391 Age < 1 yr
99382 Age 1-4 yrs	99392 Age 1-4 yrs
99383 Age 5-11 yrs	99393 Age 5-11 yrs
99384 Age 12-17 yrs	99394 Age 12-17 yrs
99385 Age 18-20 yrs	99395 Age 18-20 yrs

Billing example: New Patient EPSDT screening for a 1 month old. The diagnosis and procedure code for this service would be:

- V20.2 (Primary Diagnosis)
- 99381EP (E&M Code with "Complete" modifier)

** Enter charges. Value entered must be greater than zero ($0.00).*

Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services required to bill for a complete EPSDT screen. (Both are available in a printable PDF format online at the Provider Center at www.lacarelouisiana.com)

Completing the CMS 1500 or UB-04 Claim Form

The following blocks must be completed when submitting a CMS 1500 or UB-04 claim form for a complete EPSDT screen:

- EPSDT Referral Codes (when a referral is necessary, use the listed codes in the example below to indicate the type of referral made)
- Diagnosis or Nature of Illness or Injury
- Procedures, Services or Supplies CPT/HCPCS Modifier
- EPSDT/Family Planning

UB-04	CMS 1500	Item	Description	C/R
37	10d	Reserved for Local Use EPSDT Referrals	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YO – Other	C

UB-04	CMS 1500	Item	Description	C/R
			YV – Vision YH – Hearing YB – Behavioral YM – Medical **YD – Dental** *(Required for ages 3 and over)	C C C C C*
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, **diagnosis code V200, V201 or V202** (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, 21.4. **An appropriate diagnosis code must be included for each referral.** Immunization V-Codes are not required.	R
42	N/A	Revenue code	Enter Revenue **Code 510**	R
44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a "complete" EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	**Enter Visit Code 03** when providing EPSDT screening services.	R

Key:

- **Block Code –** Provides the block number as it appears on the claim.
- **C –** Conditional must be completed if the information applies to the situation or the service provided.
- **R** – Required – must be completed for all EPSDT claims.

Important: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

Additional EPSDT Information

Newborn Screening

Neonatal/Newborn Screening

Newborn screening (via heel stick) includes testing for 28 conditions recommended by the American College of Medical Genetics (ACMG). Conditions screened for include phenylketonuria (PKU), congenital hypothyroidism, sickle cell disease, cystic fibrosis and many other heritable disorders or diseases. Louisiana Law R.S. 40:1299.1-3 requires hospitals with delivery units to screen all newborns before discharge for these conditions, regardless of the

newborn's length of stay at the hospital. Louisiana Administrative Code (LAC:48:V.6303) also provides the State Rule requirements related to newborn screenings.

PCPs/Pediatricians are responsible for obtaining neonatal screening results. Results of the initial neonatal screening may be obtained by contacting the hospital of birth, the health unit in the parish of the mother's residence, or through Office of Public Health (OPH) Genetics Diseases Program's web based Secure Remote Viewer (SRV). You can sign-up for SRV by contacting the Genetic Diseases Program at 504-568-8254 or by following this link:

http://www.dhh.louisiana.gov/offices/miscdocs/docs263/NBS%20form/SRV%20Registration%206-23-10.pdf

Newborns must have another newborn screen if they are initially screened prior to 24 hours of age, or if results of screening are not available. The newborn infant should be rescreened at the first medical/KIDMED visit after birth, preferably between one and two weeks of age, but no later than the third week of life. This is because cases may be missed if the initial screening occurs too soon after delivery and there is a greater risk of false negative results for specimens collected from infants younger than 24 hours of age.

The initial or repeat neonatal screening results for these 28 conditions including PKU, hypothyroidism, sickle cell disease and cystic fibrosis must be documented in the medical record for all children less than six months of age. Children over six months of age do not need to be screened for these conditions unless it is medically indicated.

These tests can be performed only by the OPH Central Laboratory or another Medicaid-approved laboratory using the same testing methodologies. OPH does not charge private providers for the blue border Lab-10 filter paper form used in blood specimen collection for neonatal screening of Medicaid-eligible infants. You can obtain the form at OPH parish health units or by calling the OPH Genetic Disease Program at (504) 568-8254.

When a positive result is identified from any of these conditions and a private laboratory is used, the provider must immediately notify the Louisiana OPH Genetic Disease Program office at (504) 568-8254. The OPH Genetics Program staff will provide instruction on obtaining confirmatory testing and specialized medical management. Contact the OPH Genetics Disease Program office at (504) 568-8254 or visit the website at www.genetics.dhh.louisiana.gov for assistance and all inquiries.

Screening Eligibility and Required Services

For screening eligibility information and services required for a complete EPSDT screen, please consult the:

- EPSDT Program Periodicity Schedule and Coding Matrix
- Recommended Childhood Immunization Schedule

(Both schedules are available as Appendix 1 and Appendix 3 in the Manual and in a printable PDF format in the Provider Center at www.lacarelouisiana.com.)

You may direct EPSDT program specific questions to LaCare's Provider Services Department at **888-922-0007**.

Family and Medical History for EPSDT Screens

It is the responsibility of each network provider to obtain a Family and Medical History as part of the initial well-child examination.

The following are the Family and Medical History categories, which should be covered by the network provider:

Family History

- Hereditary Disorders, including Sickle Cell Anemia
- Hay fever - Eczema - Asthma
- Congenital Malformation
- Malignancy - Leukemia
- Convulsions - Epilepsy
- Tuberculosis
- Neuromuscular disease
- Mental Retardation
- Mental Illness in parent requiring hospitalization
- Heart disease
- Details of the pregnancy, birth and neonatal period
- Complication of pregnancy
- Complication of labor and delivery
- Birth weight inappropriate for gestational age
- Neonatal illness

Medical History

- Allergies, Asthma, Eczema, Hay Fever
- Diabetes
- Epilepsy or convulsions
- Exposure to tuberculosis
- Heart Disease or Rheumatic Fever
- Kidney or Bladder problems
- Neurological disorders
- Behavioral disorders
- Orthopedic problems
- Poisoning
- Accidents
- Hospitalizations/Operations
- Menstrual history
- Medication

Height

Height must be measured on every child at every well-child visit. Infants and small children should be measured in the recumbent position, and older children standing erect. The height should be recorded in the child's medical record and should be compared to a table of norms for age. The child's height percentile should be entered in the child's medical record. Further study or

referral is indicated in a child who has deviated from his/her usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th or below the 3rd percentile).

Weight

Weight must be measured on every child at every well-child visit. Infants should be weighed with no clothes on, small children with just underwear and older children and adolescents with ordinary house clothes (no jackets or sweaters) and no shoes. The weight should be recorded in the child's medical record, and should be compared to a table of norms for age. The child's weight percentile should also be entered in the child's medical record. Further study or referral is indicated for a child who has deviated from his usual percentile rank (determined by comparison with graphed previous measurements), or in a child whose single measurement exceeds two standard deviations from the norm for his/her age (beyond the 97th percentile or below the 3rd percentile).

Body Mass Index

Body Mass Index (BMI) should be calculated at every well-child visit using the below formula or one of the many online calculators, such as the one available from the National Heart Lung and Blood Institute (NHLBI) at www.nhlbisupport.com/bmi/.

Table: Imperial BMI Formula

$$BMI = \left(\frac{\text{weight in pounds} * 703}{\text{height in inches}^2}\right) \text{ lbs/inches}^2$$

Head Circumference

Head circumference should be measured at every well-child visit on infants and children up to the age of two years. Measurement may be done with cloth, steel or disposable paper tapes. The tape is applied around the head from the supraorbital ridges anteriorly, to the point of posteriorly giving the maximum circumference (usually the external occipital protuberance). Further study or referral is indicated for the same situations described in height and weight, and findings should be recorded in the child's medical record.

Blood Pressure

Blood pressure must be done at every visit for all children older than the age of three (3) years, and must be done with an appropriate-sized pediatric cuff. It may also be done under the age of three years when deemed appropriate by the attending network provider. Findings should be recorded in the child's medical record.

Dental Screening

Per the American Academy of Pediatric Dentistry, the first examination is recommended at the time of the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months

or as indicated by the child's risk status/susceptibility to disease. ***All children ages 3 and above must be referred for an annual dental exam as part of each EPSDT Screening***. Providers should check for the following and initiate treatment or refer as necessary:

- Cavities
- Missing Permanent Teeth
- Fillings present
- Oral infection
- Other Oral Concerns

In completing a dental referral for all children age 3 and above, providers should advise the child's parent or guardian that a referral for a dental exam is required according to the periodicity schedule. ***The provider should then contact LaCare Member Services at 888-756-0004 while the member is in the office, or within four (4) business days to notify them that the child is due for a dental referral as part of a complete EPSDT screen. LaCare Member Services will then coordinate with the member and their family and DHH to locate a participating dentist and arrange an appointment for an exam for the child.***

Documentation of the dental referral should be recorded in the child's medical record and the EPSDT Referral Code YD should be entered in field 10d on the CMS 1500 claim form, or field 37 on the UB-04 form.

Vision Testing

Technique Tips for Vision Testing

The chart should be affixed to a light-colored wall, with adequate lighting (10-30 foot candles) and no shadows. Ordinary room lighting usually does not provide this much light and the chart will need a light of its own. The 20-foot line on the chart should be set at approximately the level of the eyes of a six (6) year old. Placement of the child must be exactly at 20-feet. Sites that do not have a 20-foot distance at which to test should obtain a 10-foot Snellen chart rather than convert to the 20-foot chart. The eye not being tested must be covered with an opaque occluder; several commercial varieties are available at minimal cost, or the network provider may improvise one. The hand may not be used, as it leads to inaccuracies. In older children who seem to have difficulty or in young children, bring the child up to the chart (preferably before testing), explain the procedure and be sure the child understands.

For screening, the tester should start with the big E (20-foot line) and then proceed down rapidly line-by-line, as long as the child reads one letter per line, until the child cannot read. At this critical level, the child is tested on every letter on that line or adjacent line. Passing is reading a majority of letters in a line. It is not necessary to test for every letter on the chart. Tests for hyperopia may be done but are not required.

Referral Standards

Children seven (7) years of age and older should be referred if vision in either eye is 20/30 or worse. Those six (6) and younger should be referred if vision in either eye is 20/40 or worse. A child may be referred if parental complaints warrant or if the doctor discovers a medical reason. (Generally, sitting close to television, without other complaints and with normal acuity, is not a reason for referral.) Children failing a test for hyperopia may be referred.

Children already wearing glasses should be tested with their glasses. If they pass, record measurement and nothing further need be done. If they fail, refer for re-evaluation to a LaCare participating Specialist, preferably to the vision provider who prescribed the lenses, regardless of when they were prescribed.

If the network provider is unable to render an eye examination, in a child nine (9) years of age or older, because of the child's inability to read the chart or follow directions (e.g., a child with Mental Retardation), please refer this child to a participating Ophthalmologist.

Hearing Screening

Hearing Screening must be administered to every child 3 years of age and older.

Technique Tips for Hearing Testing

Tuning forks and uncalibrated noisemakers are not acceptable for hearing testing. For children younger than five (5) years of age, observation should be made of the child's reactions to noises and to voices, unless the child is sufficiently cooperative to actually do the audiometry. For audiometry, explain the procedure to the child. For small children, present it as a game. Present one tone loud enough for the child to hear, and explain that when it is heard, the child should raise his/her hand and keep it raised until the sound disappears. Once the child understands, proceed to the test. Doing one ear at a time, set the decibel level at 25, and testing at 500 HZ. Then go successively to 1000, 2000, 4000 and 6000. Repeat for the other ear. The quietest room at the site should be used for testing hearing.

Referral Standards

Any cooperative child failing sweep audiometry at any two frequencies should be referred to an otorhinolaryngologist or audiologist. If a child fails one tone, retest that tone with threshold audiometry to be certain it is not a severe single loss. To be certain of the need for referral, the network provider should immediately retest all failed tones by threshold audiometry, or, if there is question about the child's cooperation or ability at the time of testing, bring the child back for another sweep audiometry before referring. Please remember that audiometers should be periodically (at least yearly) calibrated for accuracy.

Development/Behavior Appraisal

Since children with slow development and abnormal behavior may be able to be successfully treated if treatment is begun early, it is important to identify these problems as early as possible. Questions must be included in the history that relate to behavior and social activity as well as development. Close observation is also needed during the entire visit for clues to deviations in those areas. The completion of a structured developmental screen is required for ages 9 – 11 months, 18 months and 30 months. Use procedure code 96110 to report the completion of this screen.

Younger than five (5) years of age

In addition to history and observation, some sort of developmental evaluation should be done. In children who are regular patients of the network provider site, this may consist of on-going recording, in the child's chart, of development milestones sufficient to make a judgment on developmental progress. In the absence of this, the site may elect to do a Denver Developmental Test as its evaluation.

- Marked slowness in any area should be cause for a referral to a participating Specialist, e.g., developmental center, a MH/MR agency, a development Specialist, a pediatric neurologist or a psychologist. If only moderate deficiencies in one or more areas are found, the child should be re-tested in 30-60 days by the network provider
- Social Activity/Behavior - Questions should be asked to determine how the child relates to his family and peers and whether any noticeable deviation in any of his/her behavior exists. The network provider should observe for similar behavior in the office
- Speech Development - Attention should be paid to the child's speech pattern to see whether it is appropriate for age. The DASE test may be used as an evaluation

For information on the Early Intervention System, please refer to the Special Needs and Case Management section of this Manual.

Five (5) years of age and older

Since the usual developmental tests are not valid at this age, observation and history must be used to determine the child's normality in the areas listed below. Each child should be checked and recorded appropriately. Major difficulty in any one area, or minor difficulty in two or more areas, should be cause for referral to a participating mental health professional for further diagnosis.

- Social Activity/Behavior - Does the child relate with family and peers appropriately?
- School - Is the child's grade level appropriate for his/her age? Has the child been held back in school?
- Peer Relationships
- Physical/Athletic Dexterity
- Sexual Maturation -Tanner Score.
- Speech - DASE Test if there is a problem in this area record accordingly, refer appropriately

Autism Screening

A structured autism screen is required at ages 18 months and 24 months. Use procedure code 96110, and modifier U1 to report the completion of this screen.

Anemia Screening

Initial measurement of hemoglobin or hematocrit is recommended between 9 and 11 months of age, and required by the 12-month screen. After this, a hematocrit should only be performed if indicated by risk assessment and/or symptoms. All premature or low-birth weight infants should have hemoglobin or hematocrit done on their first well-visit and then repeated according to the schedule above. The results of the test should be entered in the child's medical record.

Diagnosis of anemia should be based on the doctor's evaluation of the child and the blood test. It is strongly suggested that a child with 10 grams of hemoglobin or less (or a hematocrit of 30% or less) be further evaluated for anemia. However, even though 10 grams may represent the lower limit of norm for most of childhood, it should be realized that in early infancy and adolescence these levels should be higher. For those network providers who use charts to evaluate hemoglobin/hematocrit normals, it should be emphasized that average or mean

hemoglobin/hematocrit for age is not the level to determine anemia, but rather two standard deviations below the mean.

Sickle Cell

Infants younger than 8 months of age with African-American, Puerto Rican, or Mediterranean parentage should have a sickle test on their first well-child visit, to determine the possibility of sickle cell disease being present. After that age, all children of African-American, Puerto Rican, or Mediterranean parentage should have a sickle test only if they exhibit symptoms of anemia or have an hemoglobin/hematocrit below the normal levels outlined above, unless they have already been tested and the results are known.

Tuberculin (TB) Test

The American Academy of Pediatrics recommends that a child at high risk for TB exposure should be tested for tuberculosis annually, using the Mantoux test. High risk is identified as:

- Contacts with adults with infectious tuberculosis
- Those who are from, or have parents from, regions of the world with high prevalence of tuberculosis
- Those with abnormalities on chest roentgenogram suggestive of tuberculosis
- Those with clinical evidence of tuberculosis
- HIV seropositive persons
- Those with immunosuppressive conditions
- Those with other medical risk factors: Hodgkin's disease, lymphoma, diabetes mellitus, chronic renal failure, malnutrition
- Incarcerated adolescents
- Children frequently exposed to the following adults: HIV infected individuals, homeless persons, users of intravenous and other street drugs, poor and medically indigent city dwellers, residents of nursing homes, migrant farm workers

Children with no risk factors who live where TB is not common do not need TB tests. Children at high risk (see list above) should be tested every year.

Children who live in places where TB is common or whose risk is uncertain should receive Mantoux tests at 1, 4, 6 and 11-16 years of age at least.

It is the responsibility of the PCP's office to secure the results of the TB Test forty-eight to ninety-six (48-96) hours after it has been administered. TB Testing should begin at twelve (12) months, or first well-child visit thereafter, and then at two (2) year intervals, (or yearly, if high risk). Results should be entered in the child's medical record.

Albumin and Sugar

Tests for urinary albumin and sugar should be done on every child routinely at every well-visit. Dip sticks are acceptable. Positive tests should be suitably followed up or referred for further care. A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

Cholesterol Screening

Cholesterol (Dyslipidemia) screening is a required component at 18 years of age; if not completed at the 18 year screening it must be done at either the 19 or 20 year screening.

Lead Level Screening

The incidence of asymptomatic Undue Lead Absorption in children six (6) months to six (6) years of age is much higher than generally anticipated. The Centers for Medicare and Medicaid Services (CMS) and Louisiana have stringent requirements for Lead Toxicity Screening for all Medicaid eligible children.

- All Medicaid eligible children are considered at risk for lead toxicity and MUST receive blood lead level screening tests for lead poisoning
- PCPs are required (regardless of responses to the lead screening questions) to ensure that children receive a blood lead level screening test beginning at nine months of age and again before their second birthday
- Risk questions should be asked at every visit thereafter

Note: This service is only covered when Louisiana guidelines, as appropriate, are followed. Blood lead screenings are to be provided to your patients between the ages of 9-19 months and before the 3rd birthday.

Our representatives are available to you for any questions regarding this problem, its screening details, its diagnosis or its follow-up by calling the EPSDT Outreach Program at **888-922-0007**.

Gonorrhea, VDRL, Chlamydia and Pap Smear

These tests are to be performed when, in the judgment of the PCP, they are appropriate. Adolescents should be questioned about sexual activity and given assistance, diagnosis, treatment or information as the situation requires. Adolescents who are sexually active should be tested for Chlamydia.

Bacteriuria

Tests for bacteriuria must be done on any child who has symptoms relating to possible urinary tract involvement. Routinely at every screen the simple Nitrate Test by dip stick is acceptable for bacteriuria testing. Although it is best done on a first morning specimen, it may be done on a random specimen. A single dipstick is available to test for albumin, sugar, and bacteria.

Immunizations

Both State and Federal regulations request that immunizations be brought up to date during health screenings and any other visits the child makes to the office. The importance of assessing the correct immunization status cannot be overly stressed. In all instances, the network provider's records should show as much immunization history as can be elicited, especially the date of all previous immunizations. This will provide the necessary basis for further visits and immunizations.

The American Academy of Pediatrics (AAP) recommended immunization schedule is located in Appendix 4 of the Manual.

LaCare will reimburse for vaccines not provided under other programs or vaccines administered to members over the age of 18.

Pharmacy Services

For physician-administered injectable drugs, Providers are reimbursed using specific HCPCS CODES, units, amounts and NCD codes. These drugs are reimbursed at the Louisiana Medicaid fee schedule amounts. All other pharmacy services are covered through the DHH program, more information and the formulary can be found at **www.lamediciad.com**

Podiatry Services

LaCare members are eligible for all Medically Necessary podiatry services, including x-rays, with a referral written by the PCP to a podiatrist in the Network. It is recommended that the PCP use discretion in referring members for routine care such as nail clippings and callus removal, taking into consideration the member's current medical condition and the medical necessity of the podiatric services.

Podiatry Services/Orthotics

Network providers may dispense any Medically Necessary orthotic device compensable under the CCN Program upon receiving Prior Authorization from the LaCare's Utilization Management Department at 1-888-913-0350. Questions regarding an item should be directed to the Provider Services Department at **888-922-0007**.

Preventable Serious Adverse Events Payment Policy

This sets forth LaCare Health Plan's payment policy regarding Preventable Serious Adverse Events. It is LaCare's policy to deny payment for Preventable Serious Adverse Events (PSAEs) that occur during an inpatient admission.

Definitions

LaCare has adopted the following definitions:

- **Preventable**. Describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
- **Serious**. Describes an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven (7) days or still present at the time of discharge from an inpatient facility; or when referring to other than an Adverse Event, an Event the occurrence of which is not trivial.
- **Adverse**. A negative consequence of care that results in unintended injury or illness, which may or may not have been Preventable.
- **Event**. Means a discrete, auditable, and clearly defined occurrence.

Case Identification

The following processes will be followed to identify cases warranting further review to determine whether a PSAE has occurred:

- **Case Review; Outlier and Quality Review**. Serious Adverse Events may be identified by LaCare through case review, outlier and quality reviews and other claims reviews by our

utilization management and quality management staff, to determine whether the Event constituted a PSAE. Included in Appendix 17 of this manual as **NQF Serious Reportable Events in Health Care** is a list of "never" events that would trigger such a review; these Events are also posted in the Provider Section of the LaCare Website. These Events are adapted from the National Quality Forum's "Serious Reportable Events in Health care."

- **Claims Review**. Claims with one or more of the identified codes listed in "Preventable Serious Adverse Event Screening Codes (ICD-9 and E Codes)", not present at the time of admission, but appearing on the claim at discharge, will be flagged for review. A list of these codes, as of April 1, 2009 is included in Appendix 18of this manual as **Preventable Serious Adverse Event Screening Codes**. These codes can also be found in the Provider section of the LaCare Website. If a claim is flagged for review, the member's entire inpatient medical record, as appropriate, will be requested.
    - In order to make a payment determination concerning the PSAE, LaCare must receive the medical record within **thirty (30) days** of the request. LaCare may deny the claim, or recover any payment already made on the claim, for failure to submit records within the requested timeframe.
    - Upon receipt of the complete medical record, LaCare will conduct a medical review in conjunction with the submitted claim, to ensure that payment is made only for services unrelated to the PSAE and that payment, if necessary, is adjusted.
    - If the record substantiates that the payment conditions outlined below have been met, provider payment will be denied or adjusted accordingly.
    - LaCare will provide a written notice of its decision as to whether or not a "Preventable" Event has occurred and whether other payment conditions have been met so as to warrant a denial or adjustment of payment. The notice will provide the reason(s) for the decision and will outline the hospital's appeal rights and instructions for requesting a Formal Provider Appeal.

These are among the primary means that LaCare will use to identify possible PSAEs; however, they are not the only means, and the diagnosis codes and events listed in the attachments to this letter are not intended to be exclusive or exhaustive lists.

Payment Conditions

LaCare will recover, reduce or deny payment to acute care hospitals if the following criteria are met:

- The Event is **Preventable**.
- The Event is **within control of the hospital**. The hospital has policies and procedures in place to assure appropriate patient treatment and safety based on nationally accepted standards of care (e.g., JCAHO, NQF, AOA, CMS), but the Event represents a break in the hospital's policies or procedures.
- The Event must occur **during an inpatient hospital admission**.
- The Event must be **Serious**.

LaCare will recover, reduce or deny payment only for the care made necessary by the PSAE. To ensure appropriate payment, please do the following:

- If a condition described as a "never" event (See **NQF Serious Reportable Events in Health Care** in the Appendix of this manual) leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment.
- When submitting a claim that includes treatment as a result of a PSAE, hospitals are to include the appropriate ICD-9 diagnosis codes, including applicable external cause of injury or E codes on the claim. Examples of ICD-9 and "E" diagnosis codes can be found in Appendix 17, and on the LaCare Website under **Preventable Serious Adverse Event Screening Codes**. Please note that this list is not an "all-inclusive" list of codes.
- If during an acute care hospitalization, a PSAE causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

Rehabilitation

If a member requires extended care in a non-hospital facility for rehabilitation purposes, LaCare's Utilization Management Department will provide assistance by coordinating the appropriate placement, thus ensuring receipt of Medically Necessary care. A Utilization Management Coordinator will conduct Concurrent and Retrospective Reviews for all inpatient rehabilitation cases. The Utilization Management Department can be reached at **888-913-0350**.

Vision Care

Vision Benefit Administrator

LaCare's routine vision benefit for children and enhanced benefit for adults is administered through Vision Service Plan (VSP). Inquiries regarding routine eye care and eyewear should be directed to the Vision Provider Relations Department at 1-800-877-7195or you may want to visit the Website at www.VSP.com. Practitioners who are not part of the vision Network can call VSP's Professional Affairs Department at 1-800-615-1883for general inquiries. Medical treatment of eye disease is covered directly by LaCare. These inquiries should be directed to LaCare's Provider Services Department at **888-922-0007**.

Corrective Lenses for Children (Younger Than 21 Years of Age):

Members younger than 21 years of age are eligible for routine eye examinations once every calendar year, or more often if Medically Necessary. No referrals are needed for routine eye exams. Members are also eligible to receive two pairs of prescription eyeglasses, every 12 months, or more often if Medically Necessary. Members younger than 21 years of age are also eligible to get prescription contact lenses.

If the prescription eyeglasses are lost, stolen or broken, LaCare will pay for them to be replaced, if approved. Please contact VSP's Provider Relations Department at 1-800-877-7195 to obtain an approval. Lost, stolen or broken prescription contact lenses will be replaced with prescription eyeglasses.

- Members may choose from two select groups of eyeglass frames at no charge; or
- They may choose from a select group of premier eyeglass frames for a co-payment of $25.00; or
- They may choose eyeglass frames that are not part of the select groups and LaCare will pay a portion of the cost, up to $40.00, whichever is less.

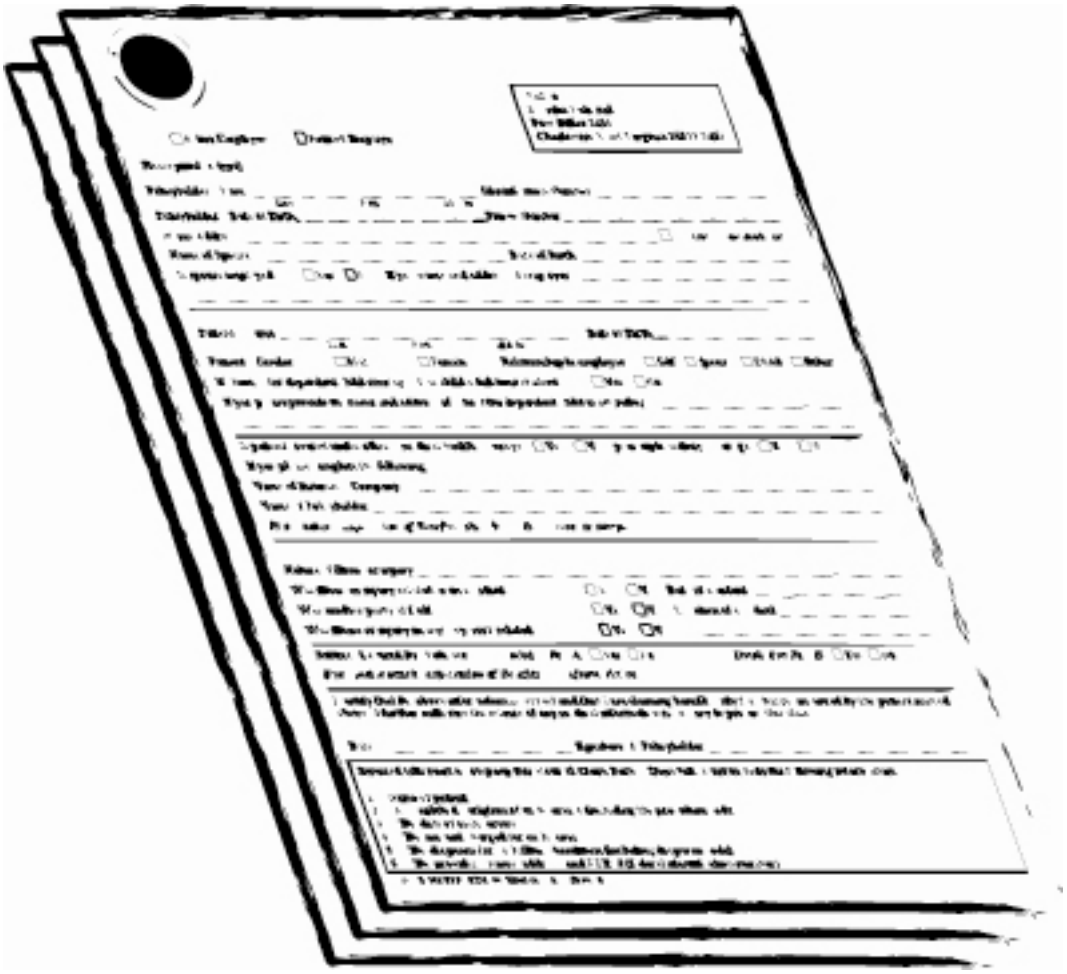
- If prescription contact lenses are chosen, LaCare will pay for the cost of the prescription lenses or $75.00, whichever is less.

There are special provisions for members with aphakia or cataracts. Please refer to "Eye Care Special Provisions" topic (below) in this section of the Manual.

- Eye Care Benefits for Adults (21 Years of Age and Older):
- Routine eye exams are covered once 24 months. No referral is needed for the the first routine eye exam, but there is a $10 co-pay. LaCare will offer a $40 allowance toward the purchase of eyeglasses (frame and lenses) every 24 months.

There are no other adult optician/eyewear benefits.

Section V
Claims Disputes and Provider Complaints



LaCare Claims Filing Instructions

Detailed LaCare Claims Filing Instructions can be accessed online in the Provider Center at **www.lacarelouisiana.com**

In addition, The Claims Filing Instructions are in Appendix 26.

The Claims Filing Instructions contain current information and are periodically updated as needed. In Appendix 26, you will also find sample CMS 1500 and UB04 claim forms and required fields. These instructions cover both electronic and paper claim submissions.

National Provider Identification Number

The National Provider Identifier (NPI) is a Federally-issued10-digit unique standard identification number that all health care providers must use when submitting electronic claims effective May 23, 2008.

Electronic claims submitted without an NPI will be rejected back to the provider via their EDI clearinghouse. Network providers who submit claims via paper CMS 1500 or UB-04 are also required to include their NPI on their claims.

How to Apply for Your NPI

Health care providers may apply for their NPI in one of the following ways:

- Complete the web-based application at https://nppes.cms.hhs.gov. This process takes approximately 20 minutes to complete
- Call the Enumerator call center at 1-800-465-3203 or TTY 1-800-692-2326 to request a paper application
- E-mail customerservice@npienumerator.com to request a paper application
- Request a paper application by mail:

  NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059

NOTE: The most time-efficient method of getting an NPI is the web-based application process.

Reporting your NPI(s)

Network providers must report their practice and individual NPIs to us in order to record them in the claims processing system. Once the practice and individuals in the practice have obtained an NPI, the following four steps to report NPIs to LaCare should be completed.

1. Use the submission form to report practice and individual NPIs. The submission form includes information specific to a practice, as well as a listing of individual participating practitioners at the office location. The submission form can be found in the Provider Center at www.lacarelouisiana.com. For a printed copy, please call **888-922-0007**.
2. Report the corresponding Primary Provider Taxonomy Code for the practice and each individual participating practitioner at the office location as reported on the NPI

application(s). The Provider Taxonomy code, a 10-character alphanumeric identifier, indicates provider specialty and will assist LaCare in verifying NPIs for Claims processing. Information on Provider taxonomy codes is available at www.wpc-edi.com/taxonomy.

3. Attach copies of NPI confirmation, issued to the practice and each individual participating practitioner at the office location, by the National Provider Identifier Enumerator. LaCare will use the NPI confirmation for verification purposes.
4. Return the completed submission form, along with practice and individual NPI confirmations by mail:

   Attention: Provider Maintenance
   LaCare Health Plan
   200 Stevens Drive
   Philadelphia, PA 19113

   Or

Electronically to LaCare. Visit the Provider Center at www.lacarelouisiana.com and click on the NPI on-line submission tool.

Additionally, LaCare encourages Providers to participate/enroll in the in the Louisiana Medicaid program. Participation is not a requirement but a provider cannot be excluded from program participation or they cannot participate with LaCare.

Prompt Pay Requirements

LaCare is required by the Louisiana Department of Health and Hospitals to meet the following:

- All provider claims that are clean and payable must be paid according to the following schedule.
- Ninety percent (90%) of all cleans claims of each provider type must be paid within fifteen (15) business days of the date of receipt (the date the CCN receives the claim as indicated by the date stamp on the claim).
- Ninety-nine percent (99%) of all clean claims of each provider type must be paid within thirty (30) calendar days of the date of receipt.
- The date of payment is the date of the check or other form of payment
- LaCare must pay providers interest at 12% per annum, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid the same date that the claim is adjudicated
- LaCare must process all appealed Claims to a paid or denied status within (30) Business Days of receipt of the Appealed Claim

Claim Filing Deadlines

Original Claims

Original Claims must be submitted to LaCare within 12 months from the date services were rendered or date compensable items were provided.

Re-submission of Rejected Claims

Re-submission of **rejected Claims must occur within 12 months** from the date of service or date compensable items were provided.

Re-submission of Denied Claims

Re-submission of previously Denied Claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date of service or date compensable items were provided. For more information on billing requirements, please see the Claims Filing Instructions in the Provider Center at www.lacarelouisiana.com

Submission of Claims Involving Third Party Liability

If a member has other insurance coverage in addition to LaCare coverage, the other insurance carrier (the "Primary Insurer") must consider the Health Care Provider's charges before the Claim is submitted to LaCare. Therefore, health care providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health care providers then may bill LaCare for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. **Claims with EOBs from Primary Insurers must be submitted within 60 days of the date of the Primary Insurer's EOB.**

Failure to Comply with Claim Filing Deadlines

LaCare will not grant exceptions to the Claim filing timeframes outlined in this section unless LaCare (or our vendor) caused the delay. If the Provider files erroneously with another CCN plan but produces documentation verifying the initial filing of the claims occurred within the 356 day period, the claim will be paid. Failure to comply with these timeframes will result in the denial of all Claims filed after the filing deadline. Late Claims paid in error shall not serve as a waiver of LaCare's right to deny any future Claims that are filed after the deadlines or as a waiver of LaCare's right to retract payments for any Claims paid in error.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than LaCare. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as LaCare, are always the **payer of last resort.** This means that all other insurance carriers (the "Primary Insurers") must consider the Health Care Provider's charges before a Claim is submitted to LaCare. Therefore, before billing LaCare when there is a Primary Insurer, health care providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health care providers then may bill LaCare for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Reimbursement for Members with Third Party Resources

.

Commercial Third Party Resources

For services that have been rendered by a network provider, LaCare will pay, up to the LaCare contracted rate, the lesser of:

- The difference between the LaCare contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and LaCare will not exceed LaCare's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, LaCare will pay coinsurance, deductibles and/ or co-payments up to the applicable Louisiana Fee-For-Service rate.

Health care providers must comply with all applicable LaCare referral and authorization requirements.

Fraud & Abuse

LaCare receives state and federal funding for payment of services provided to our members. In accepting Claims payment from LaCare, health care providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or abuse against the Medicaid program. As a provider you are responsible to know and abide by all applicable State and Federal Regulations.

LaCare is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including the Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as local authorities.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services

- Failure to perform services required under a capitated contractual arrangement

Contact Information

To report or refer suspected cases of Fraud and abuse you may contact LaCare's Fraud and Abuse Hotline by:

Phone:

1-866-833-9718

Mail:

Corporate and Financial Investigations
LaCare Health Plan
200 Stevens Drive
Philadelphia, PA 19113

Provider Complaints and Claims Disputes

Informal Disputes

LaCare's goal is to assure smooth transactions and interactions with our Provider Network community. We are happy to address any verbal or written complaint by a provider and hope to be able to resolve complaints quickly. We understand that providers can interact with multiple staff from LaCare so we train all staff to route your concerns to the appropriate person to log your concern and assist in resolution. We do, however, strongly encourage providers to try to resolve their concerns by calling the 888-922-0007. Staff answering the Provider Line are trained to work to resolve provider complaints such as :

- Dissatisfaction with a LaCare policy
- Dissatisfaction with interaction with LaCare staff
- Claims Payment issues/questions

There is a special unit trained for claims issues. All calls to our Provider Claims Services Line are also logged and tracked. Often, the issue can be resolved during the call. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a formal Claims Dispute, which is described in more detail at the end of this Section. Please review the section below prior to filing an informal or formal complaint

Common Reasons for Claim Rejections & Denials

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. Some examples are illegible Claim fields or missing or invalid codes and/or missing or invalid member or Provider ID numbers. Rejected Claims are returned to the Health Care Provider or EDI source without registration in our Claim processing system. Since rejected Claims are not registered in the Claim processing system, the Health Care Provider must re-submit corrected Claims within 12 months from the date of service or date compensable items provided. This requirement applies to Claims submitted on paper or electronically. Rejected Claims are different than Denied Claims, which are registered in the Claim processing system but do not meet requirements for payment under Plan guidelines. Resubmit rejected Claims following the same process you use for original Claims - 12 months from the date of service or date compensable items provided.

Claims Denied for Missing Information

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information from the Health Care Provider is missing must be resubmitted for correction. Some examples are a missing Tax ID number, incomplete information or incorrect coding. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health care providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate "Corrected Claims" on the Claim form:

Corrected Claims/Adjusted Claims
LaCare Health Plan
P.O. Box 7322
London, KY 40742

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. Provider Services Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

Emergency Department Payment Level Reconsideration

In certain cases, it is not necessary for a hospital Provider to appeal a Claim decision when they are not in agreement with LACARE's level of payment for Emergency Room services. If a Claim has been reimbursed at the lower degree of acuity rate, and the original Claim submission did not include medical records or the Emergency Room summary, the hospital Provider may resubmit the Claim along with medical records (or Emergency Room Summary) for payment level reconsideration. LACARE's clinical staff will review the medical records and render a decision based on the nature of treatment rendered to treat presenting symptoms. These Claims should be submitted to the Claims Medical Review Department at the following address:

Claims Medical Review Department

LACARE Health Plan
P.O. Box 7322
London, KY 40742

Hospital Providers will be notified via the remittance advice of any decisions to pay at the higher degree of acuity rate. If review of the medical records does not indicate services should be paid at the higher degree of acuity rate, a letter will be sent to the hospital Provider upholding the original Claim determination. If the hospital Provider disagrees with this determination, the hospital Provider may file a Formal Provider Appeal for further reconsideration of the level of payment. For information on how to file, please refer to Formal Provider Appeal procedures outlined in Section VII.

Payment Limitations

No payment will be made for Emergency Room services if:

- The Member is not eligible for benefits on the date of service
- The Member is admitted to an SPU, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU, Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section II for notification requirements

Formal Provider Disputes Process

If the provider continues to be dissatisfied after informal attempts to resolve a complaint, including claims disputes, the section below outlines the process for formal dispute resolution.

Definitions:

Provider Complaint - expression by a provider that indicates dissatisfaction or dispute with CCN policy, procedure, claims processing and/or payment, or any aspect of CCN functions. When a provider files a complaint either formally or informally, it becomes a dispute.

Provider Appeal - **A provider appeal is the formal mechanism that allows a provider to appeal a LaCare final medical necessity decision.** Providers may not use the Provider Dispute Process for a Provider Appeal . The process to appeal medical necessity decisions can be found in Section X. This chapter explains our internal medical necessity appeal process and the right of a provider to file an appeal on behalf of a member.

Examples of Complaints

Examples include, but are not limited to:

- Service issues with LaCare, including failure by LaCare to return a Provider's calls, frequency of site visits by LaCare's Network Development Representatives and lack of Provider Network orientation/education by LaCare
- Credentialing concerns such as timeliness, allegation of a discriminatory practice or policy.
- Claims Disputes including Claim denials, payments the network provider feels were made in error by LaCare, or those claims issues that involve a larger volume of Claims than can easily be handled by phone.
- Claims Disputes also include Administrative denials such a failure to request Prior Authorization when required, failure to obtain a referral prior to performing a service.
- Issues with LaCare processes, including failure to notify network providers of policy changes, dissatisfaction with LaCare's Prior Authorization process, dissatisfaction with LaCare's referral process and dissatisfaction with LaCare's Formal Provider Complaint Process
- Contracting issues, including dissatisfaction with LaCare's reimbursement rate, incorrect capitation payments paid to the network provider and incorrect information regarding the network provider in LaCare's Provider database

Filing a Formal Dispute

Formal Disputes including Claim and Administrative denials must be in writing and must be filed within 30 days of the original denial or proposed resolution to an informal dispute. Formal Disputes must be mailed to the address below:

Provider Network Management Department
LaCare Health Plan
PO Box 7323
London, KY 40742
Attention: FORMAL DISPUTE

On-Site Meeting

Network providers may request an on-site meeting with a Network Development Representative, either at the network provider's office or at LaCare to discuss the Dispute. Depending on the nature of the Dispute, the Network Development Representative may also request an on-site meeting with the network provider. The network provider or Network Development Representative must request the on-site meeting within seven (7) calendar days of the filing of the Formal Dispute with LaCare. The Network Development Representative assigned to the network provider is responsible for scheduling the on-site meeting at a mutually convenient date and time.

Claims Dispute Documentation

For accurate and timely resolution of issues, network providers should include the following

- Provider Name
- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- As detailed a description of the denial issue as possible.

If numerous Claims are impacted by the same issue, LaCare has developed a spreadsheet format for submission of larger Claims projects. The spreadsheet format can be found in Appendix 19 or online in the Provider Center at www.lacarelouisiana.com. If several Claims have been denied for the same reason, these may all be included in a single letter/E-mail with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet.**

Time Frame for Resolution

LaCare will investigate, conduct an on-site meeting with the network provider (if one was requested), and issue the resolution of the Dispute within thirty (30) calendar days of receipt of the Formal Dispute from the network provider.

Second Level Dispute Resolution:

If the provider continues to be dissatisfied with the proposed resolution of his or her complaint or claims dispute, the provider has the following options.

File a written Second Level Dispute – including any additional information.

The second Level Dispute should be sent to:

Provider Network Management Department
LaCare Health Plan
PO Box 7327
London, KY 40742
Attention: SECOND LEVEL FORMAL DISPUTE

Second Level Claims Disputes are referred to an external Independent Reviewers. All previously submitted documentation along with any additional material submitted by the provider will be forwarded to the Independent Review Organization.

Second Level Disputes about claims policy and procedures (such as NCCI or other edits) – will also be forwarded to THE INDEPENDENT REVIEW ORG.

Second Level Formal Disputes unrelated to Claims (such as a credentialing policy) will be reviewed and decided upon by a Dispute Committee of at least three (3) individuals who review second level Formal Disputes. The Committee is comprised of the following:

- Independent Review Organization (if applicable)
- Manager of Provider Network Management or his/her designee
- Manager of Operations or his/her designee
- Manager of Medical Services or his/her designee

The Second Level Formal Dispute resolution will be decided within thirty (30) days of receipt of the dispute. The decision is final and will not be reconsidered.

Disputes about Non LaCare Covered Services

Louisiana's Coordinated Care Network Program provides Medicaid covered services for members in the CCN Plans but not all Medicaid services are included in the Plans core benefits. For example, pharmacy (other than specialty drugs associated with J codes) is still covered by the Department of Health and Hospitals (DHH). Specialized Behavioral Health Services are covered by a behavioral plan. Disputes involving LaCare covered services are covered by the Provider Complaint Systems described in this section. How to access Medicaid Services not covered by LaCare is covered in Section XII. However, there may be tomes when a provider has a dispute regarding these non-LaCare services. Our Provider Services Department can assist a provider in identifying whether the issue in dispute is a Plan or DHH responsibility.

Disputes can also involve larger issues of policy and procedure. When the source of the dispute is a rule or issue where DHH is the ruling entity, our Member Service staff can help you redirect your complaint. .

Section VI
Provider Services

NaviNet

NaviNet offers your practice full-circle services from visit to claim payment and beyond for no charge! Using NaviNet reduces the time spent on paperwork and allows you to focus on more important tasks – patient care. NaviNet is a "one-stop" service that supports your office's clinical, financial and administrative needs. Log on to www.navinet.net or contact NaviNet Customer Service at 1-888-482-8057 to help you get started.

NaviNet Supports Pre-Visit Functions

- Eligibility and Benefits Inquiry
  - Real-time access to member eligibility and benefits
- Care Gaps
  - A summary of the age/sex/condition appropriate health screens that a member should have
- Care Gap Alerts*
  - Care Gap notification that appears when checking member eligibility
  - View and print for members coming in to your office. Place them with the patient's medical chart so they can be addressed during the visit.
- Care Gap Reports*
  - Customizable reports that can be used to target at risk members
  - Can be downloaded and faxed back to LaCare with updated information

* ***Note:*** Utilizing these tools to close gaps in care improves your opportunity for incentive dollars through LaCare's Quality Care Compensation Program.

Member Clinical Summary*

- A virtual snapshot of a patient's relevant clinical facts and demographic information in a user-friendly format. Member clinical summaries enable your practice to secure a more complete view of established patients and provide valuable information on new patients.
- The summary can be exported into EMR systems (CCD format). Member Clinical Summaries include the following information:
  - Demographic information
  - Chronic conditions
  - ER Visits (within the past 6 months)
  - Inpatient Admissions (within the past 12 months)
  - Medications (within the past 6 months)
  - Office Visits (within the past 12 months)

* ***Note:*** Your NaviNet Security Administrator will need to turn on access to this information for designated users in their NaviNet security profile, as this summary contains extensive personal health information.

NaviNet Supports Patient/Provider Visits

- Care Gaps (see Pre-Visit section above)
  - Use the care gap reports to provide your patients with appropriate and needed health screenings
  - Maximize your opportunity for incentive dollars
- Member Clinical Summary (see Pre-Visit section above)

- Referral Submission/Inquiry
    - NaviNet functionality allows primary care providers to submit real-time electronic referrals (valid for 180 days)
    - PCPs, Specialists, Hospitals and Ancillary Providers can search, retrieve and print electronic referrals

NaviNet Supports Claims Management Functions

- NaviNet functionality allows your practice to:
    - Check the status of submitted claims
    - View claim EOBs
    - Perform claim adjustments– Coming soon!
    - Direct claim entry – Coming soon!

NaviNet Supports Back Office Functions

- Panel Roster
    - Mirrors the report primary care providers receive in the mail
    - Provides easy and immediate access
    - Contains panel report plus historical reports for the past six months
    - Reports can be imported into Excel for sorting and/or mailing to targeted patients
    - Reports can be integrated with your practice management system
- Intensive Case Management Reimbursement Program
    - Identify members with chronic and/or complex medical needs
    - Assure chronically ill members are routinely accessing Primary Care services
    - Report complete and accurate diagnosis and disease acuity information
    - Update LaCare on chronically ill patients and submit claims for reimbursement
- Other NaviNet Reports
    - Quality Care Compensation Program Profiles
    - Quality Care Compensation Program Detail Reports (coming soon!)
    - Supplemental reports validating performance ranking

EDI Technical Support Hotline

LaCare has an EDI Technical Support Unit within the Information Solutions Department to handle the application, set-up and testing processes for electronic Claim submission. Please call the toll-free EDI Hotline at **1-877-234-4271** with any EDI inquiries, questions, and/or electronic billing concerns. More detailed information is available in the Claims Filing Instructions at www.lacarelouisiana.com.

Some benefits of electronic billing include:

- Faster transaction time for Claims
- Reduction in data entry errors on Claims processed
- The ability to receive electronic reports showing receipt of Claims by the insurance plan

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

EFT simplifies the payment process by:

- Providing fast, easy and secure payments
- Reducing paper
- Eliminating checks lost in the mail
- Not requiring you to change your preferred banking partner

Enroll through our EFT partner, Emdeon Business Services

For detailed information and instructions log on to www.lacarelouisiana.com and click on the EFT link

ERA – Call Emdeon's customer service to sign up for electronic remittance advice: 1-877-363-3666

Provider Network Management

Provider Network Management is responsible for building and maintaining a robust Provider Network for members. Contracting staff is responsible for negotiating contracts with hospitals, physicians, ancillary, DME and other providers to assure our Network can treat the full range of MA covered benefits in an accessible manner for our members.

The primary contact for network providers with LaCare is the Network Development Representative. Network Development Representatives are responsible for orientation, continuing education, and diplomatic problem resolution for all network providers. A Network Development Representative will act as your liaison with LaCare. Network Development Representatives visit network provider locations to conduct in-service/orientation meetings with network providers and their staff both pro-actively and in response to network provider issues involving policy and procedure, reimbursement, compliance, etc.

Provider Network Management, in collaboration with the Utilization Management Department, negotiates rates for Non-Participating Providers and facilities when services have been determined to be Medically Necessary and are Prior Authorized by LaCare.

Call your Network Development Representative at **888-922-0007**:

- To arrange for orientation or in-service meetings for network providers or staff
- For service calls
- To respond to any questions or concerns regarding your participation with LaCare
- To report any changes in your status, e.g.:
    - Phone number
    - Address
    - Tax ID Number
    - Additions/deletions of physicians affiliated with your practice

Provider Demographic Information

Network providers should contact their Network Development Representative or Provider Services with changes to their demographic information. Network providers may verify their demographic data at any time using the "real-time" Provider Network directory at www.lacarelouisiana.com

Accurate provider information is imperative to successful participation in our network. Correct phone numbers and addresses are necessary for our members to make appointments and find your office location. Correct NPIs, Tax IDs and remit addresses are necessary for you to be properly reimbursed for your services. LaCare periodically sends rosters to our participating providers. We ask that this information is carefully reviewed, and verify the information. If any corrections are necessary we ask that these corrections be sent immediately to LaCare so we can correct the information we have on record.

We require advance notice, when possible, of any changes in your practice demographic information. It is your responsibility to make sure your initial submissions accurately reflect your practice, or facility, the practitioners who are in the practice. You must alert us in a timely manner should you anticipate changes. For example, we need advance notice if a provider is leaving your practice so we can notify our members and the state enrollment broker. This is especially important for primary care practices since the members assigned to that practitioner's panel must be notified and they must choose a new PCP timely.

Requests for changes to address, phone number, Tax I.D., or additions and/or deletions to group practices must be made on the Provider Change Form (form located in Appendix 20 of the Manual) or behind the secure log-in of the Provider Center on the LaCare Website at www.lacarelouisiana.com or you can mail it to the Provider Network Management Department at:

LaCare Health Plan
Provider Network Management Department
PO Box 83580
Baton Rouge, LA 70884

1-877-588-2248

Email

LaCare has the ability to send to you, via email, contracts, documents and amendments for your review and signature. It is important that we have the correct email for the person in your practice who is responsible for office management and who will route information to the correct person.

Provider Services Department

LaCare's Provider Services Department operates in conjunction with the Provider Network Management Department, answering network provider concerns and offering assistance. Both departments make every attempt to ensure all network providers receive the highest level of service available.

The Provider Services Department can be reached twenty-four (24) hours a day, seven (7) days a week. Calls received after business hours, on weekends and holidays are answered by our Off-Hours team. The Off-Hours team will contact the on-call UM nurse for any urgent issues. A Medical Director is also on-call to address any medical necessity determination requests.

Call the Provider Services Department at **888-922-0007**

- To ask policy and procedure questions
- To report member non-compliance
- To obtain the name of your Network Development Representative
- To request access/information about centralized services such as:
    - Outpatient laboratory services
    - Vision
    - Dental (limited coverage)
- To request help accessing services not covered by LaCare but covered by the FFS system for Medicaid recipients, such as:
    - Specialized Behavioral Health services
    - Pharmacy Services

Claims Issues

The Provider Services Department will also assist you with claims questions and adjustments. Some of the Claims-related services include:

- Review of Claim status (Note: Claim status inquiries can also be done online via NaviNet)
- Research on authorization, eligibility and coordination of benefits (COB) issues related to Denied Claims
- Clarification of payment discrepancies
- On-line adjustments to incorrectly processed Claims
- Assistance in reading remark, denial and adjustment codes from the Remittance Advice

Additional administrative services include:

- Explanation of Plan policies in relation to Claim processing procedures
- Explanation of referral and authorization issues related to Claim payment
- Information on billing and Claim coding requirements
- Assistance in obtaining individual network provider numbers for network providers new to an existing LaCare group practice.

Call the Provider Claim Services Unit at 888-922-0007or look online in the Provider Center on the LaCare website at www.lacarelouisiana.com

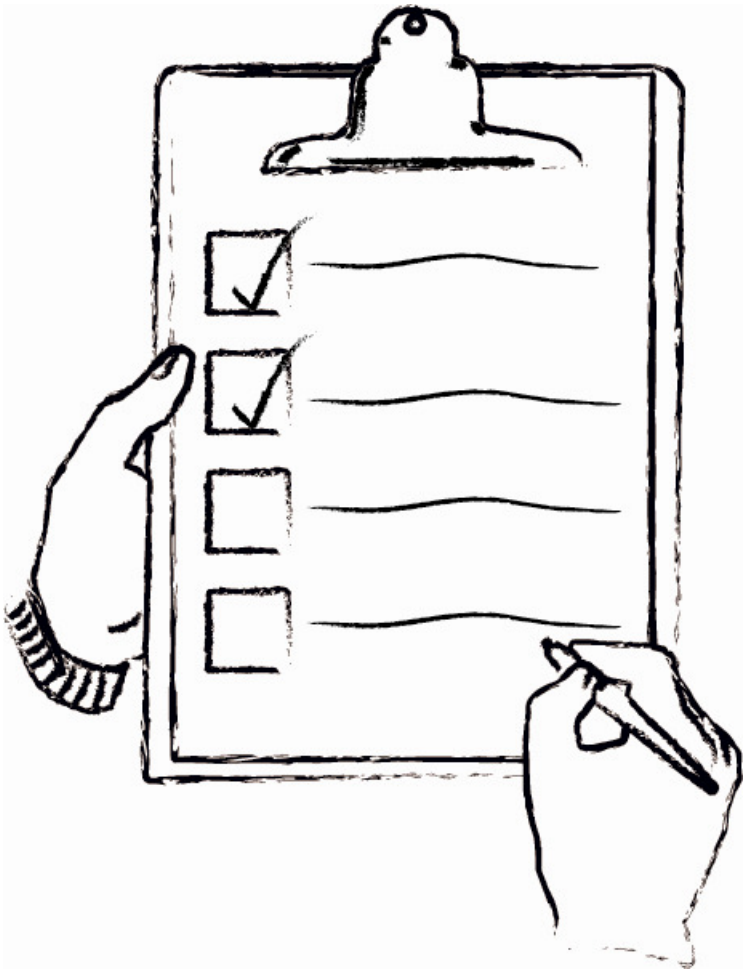
Member Services

The Member Services Department helps our members to understand and obtain the benefits available to them. Member Services Representatives are available twenty-four (24) hours a day, seven (7) days a week. Member Services Representatives also provide ongoing support and education to the LaCare membership, focusing on communicating with our members concerning their utilization of LaCare and managed care principles, policies and procedures. Call the Member Services Department at **1-888-756-0004**:

- To access on-call nurses after hours
- To assist members looking for help access care such as behavioral health information
- To identify non-compliant members

- To help educate members on how to access eligible benefits
- For more information on Special Needs services
- To ask for health education materials in other languages and formats
- To help a member choose or change a PCP or other network provider
- To request a list of network providers
- To learn what members should do if a Health Care Provider sends a bill.

Section VII
Quality Management, Credentialing, and Utilization Management



Quality Management

LaCare employs a comprehensive Quality Assessment and Performance Improvement (QAPI) Program that integrates knowledge, structure and processes throughout the health care delivery system to assess risk and to improve quality and safety of clinical care and services provided to LaCare members. The LaCare QAPI Program provides a framework for the evaluation and delivery of health care and services provided to members.

Purpose and Scope

The purpose of the QAPI Program is to provide the infrastructure to systematically monitor, objectively evaluate and ultimately improve the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to LaCare members in accordance with the following organizational mission statement:

We help people: Get care, Stay well, Build healthy communities. We have a special concern for those who are poor.

The Quality Assessment and Performance Improvement Program is also the mechanism for:

- Determining practice guidelines and standards on which the program's success will be measured
- Complying with all applicable laws and regulatory requirements such as those from DHH and other applicable state and federal agencies, and accreditation body standards
- Providing oversight of all delegated services
- Conducting member and practitioner satisfaction surveys to identify opportunities for improvement
- Ensuring that a qualified network of providers and practitioners is available to provide care and service to members through the credentialing/recredentialing process

Reducing health care disparities by measuring, analyzing and redesign of services and programs to meet the health care needs of LaCare's diverse membership

Objectives

The objectives of the QAPI Program are to:

- Maximize utilization of collected information about the quality of clinical care (physical and behavioral), health outcomes and service and identify clinical and service improvement initiatives for targeted interventions
- Evaluate access to care, availability of services, continuity of care health care outcomes, and services provided and arranged by LaCare
- Assess the quality and appropriateness of care furnished to members with special needs
- Strengthen provider capabilities and performance related to the provision of evidence-based clinical care
- Coordinate services between various levels of care, network practitioners, behavioral health providers and community resources to assure continuity of care and promote optimal physical, psychosocial, and functional wellness
- Utilize results of Participant and practitioner/provider satisfaction measures when identifying and prioritizing quality activities

- Incorporate the results of external quality evaluations (e.g. EQR results, NCQA accreditation feedback, DHH findings) and internally generated evaluations such as HEDIS, satisfaction monitoring and internal audits and monitoring into quality program activities
- Implement and evaluate condition management programs to effectively address chronic illnesses affecting the population
- Design and implement provider outreach and education activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to practitioners, providers, and members.
- Identify and implement activities that promote participant safety
- Document and report the results of monitoring activities and quality improvement initiatives to appropriate stakeholders
- Facilitate the delivery of culturally competent health care to reduce health care disparities

An annual QAPI work plan is derived from the QAPI Program goals and objectives. The work plan provides a roadmap for achievement of program goals and objectives, and is also used by the Quality Department as well as the various quality committees as a method of tracking progress toward achievement of goals and objectives

QI Program effectiveness is evaluated on an annual basis. This assessment allows LaCare to determine how well it has deployed its resources in the recent past to improve the quality of care and service provided to LaCare membership. When the program has not met its goals, barriers to improvement are identified and appropriate changes are incorporated into the subsequent annual QAPI work plan. Feedback and recommendations from various councils and committees are incorporated into the evaluation.

QM Program Authority and Structure

The Board of Directors of AmeriHealth Mercy of Louisiana, Inc. provides strategic direction for the Quality Assessment Performance Improvement (QAPI) Program and will retain ultimate responsibility for ensuring that the QAPI Program is incorporated into LaCare's operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI Program are delegated by the AmeriHealth Mercy of Louisiana, Inc. Board of Directors through the AmeriHealth Mercy of Louisiana President and the Vice President of AmeriHealth Mercy of Louisiana to the LaCare Executive Director and Quality Assessment Performance Improvement Committee (QAPIC).

Quality Assessment Performance Improvement Committee

The Quality Assessment Performance Improvement Committee (QAPIC) oversees LaCare's efforts to measure, manage and improve quality of care and services delivered to LaCare members, and evaluate the effectiveness of the QAPI Program The QAPIC directs and reviews LaCare's Quality Improvement and Utilization Management activities.

Compliance Committee

The LaCare Compliance Committee assists the Compliance Director with the implementation and oversight of the LaCare Compliance Program. The committee serves in an oversight role to ensure that LaCare is in compliance with all applicable laws, rules, regulations and contractual requirements. The LaCare Compliance Committee reports to the AmeriHealth Mercy of Louisiana, Inc. Board of Directors.

LaCare Partnership Council

The LaCare Partnership Council solicits input from provider and community stakeholders regarding the structure and implementation of new and existing clinical policies, initiatives and strategies. The Council provides input to the Provider Outreach Strategy and QAPIC, as appropriate.

LaCare Member Advisory Council

The LaCare Member Advisory Council provides a forum for member participation and input to LaCare programs and policies to promote collaboration; maintain a member-focus and enhance the delivery of services to LaCare communities.

Quality of Service Committee

The Quality of Service Committee (QSC) reports to the QAPIC. The purpose of the QSC is to assure that performance and quality improvement activities related to LaCare services are reviewed, coordinated and effective. The QSC reviews, approves and monitors action plans created in response to any identified variance.

Credentialing Committee

The Credentialing Committee is responsible for reviewing practitioner and provider applications, credentials and profiling data (as available) to determine appropriateness for participation in the LaCare network.

Second Level Provider Appeal Committee

The Second Level Provider Appeal Subcommittee reviews second level provider appeal submissions. The committee may uphold, modify or overturn the original decision.

Confidentiality

Documents related to the investigation and resolution of specific occurrences involving complaints or quality of care issues are maintained in a confidential and secure manner. Specifically, members' and health care Providers' right to confidentiality are maintained in accordance with applicable laws. Records of quality improvement and associated committee meetings are maintained in a confidential and secure manner.

Credentialing/Recredentialing Requirements

Practitioner and Provider Requirements

LaCare maintains and adheres to all applicable State and federal laws and regulations, requirements, and accreditation requirements governing credentialing and recredentialing functions.

The following types of practitioners require initial credentialing and recredentialing (every 36 months):

Audiologists	Language Pathologists *	Physicians (DOs and MDs)
Certified Nurse Midwife	Occupational Therapists *	Podiatrists
Chiropractors	Oral Surgeons	Speech Therapists

CRNP's	Physical Therapists *	Therapeutic Optometrists

* Only private practice occupational, physical, and speech therapists require credentialing.

The following criteria must be met as applicable, in order to evaluate a qualified Health Care Provider:

- A current unrestricted state license, not subject to probation, proctoring requirements or disciplinary action to specialty. A copy of the license must be submitted along with the application
- A valid DEA or CDS certificate, if applicable
- Education and training that supports the requested specialty or service, as well as the degree credential of the Health Care Provider
- Foreign trained health care providers must submit an Education Commission for Foreign Medical Graduates (ECFMG) certificate or number with the application
- Board certification is required for all Providers who apply as a specialist. LaCare requires that all specialists be board-certified or meet one (1) of the following exceptions:
    - Documented plan to take board exam
    - An associate within the group practice that the Health Care Provider is joining is board-certified in the requested specialty
    - Demonstrated Network need as determined by LaCare
- The following board organizations are recognized by LaCare for purposes of verifying specialty board certification:
    - American Board of Medical Specialties - ABMS
    - American Osteopathic Association - AOA
    - American Board of Podiatric Surgeons - ABPS
    - American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM)
    - Royal College of Physicians and Surgeons
- Work history containing current employment, as well as explanation of any gaps within the last (5) years
- History of professional liability claims resulting in settlements or judgments paid by or on behalf of the Health Care Provider
- A current copy of the professional liability insurance face sheet (evidencing coverage)
- Health care providers who require hospital privileges as part of their practice must have a hospital affiliation with an institution participating with LaCare. PCPs must have the ability to admit as part of their hospital privileges. As an alternative, those health care providers who do not have hospital privileges, but require them, may enter into a collaboration agreement with a Health Care Provider(s) who is able to admit. CRNPs and CNMs must have agreements with the covering physician
- A current CLIA (Clinical Laboratory Improvement Act) certificate or waiver of a certificate of registration along with a CLIA identification number

Provider Application (other than Facilities)

LaCare Health Plan offers practitioners the Universal Provider Datasource through an agreement with The Council for Affordable Quality Health care (CAQH) that simplifies and streamlines the data collection process for credentialing and recredentialing.

Through CAQH, credentialing information is provided to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH.

There is no charge to providers to participate in CAQH or to submit applications. LaCare encourages all providers to utilize this service.

Submit your application to participate with LaCare via CAQH (www.caqh.org):

- Register for CAQH
- Grant authorization for LaCare to view your information in the CAQH database
- Send your CAQH ID number to LaCare at (credentialing@amerihealthmercy.com) or by fax to **866-242-3461**)

LaCare Paper Application Process

- Complete a State standard application and attestation that includes signature and current date. Sign and date a release of information form that grants permission to contact outside agencies to verify or supply information submitted on the applications
- Submit all License, DEA, Board Certification, Education and Training, Hospital Affiliation and other required information with the application, which will be verified directly through the issuing agency prior to the credentialing/recredentialing decision
- Medicaid number issued by the Louisiana Medicaid Program, if required

As part of the application process, LaCare will:

- Request information on Health Care Provider sanctions prior to making a credentialing or recredentialing decision. Information from the National Provider Data Bank (NPDB), Health Integrity Provider Data Bank (HIPDB), Federation of State Medical Board (FSMB), EPLS (Excluded Parties Links System), and HHS Office of Inspector General (OIG) (Medicare exclusions), Federation of Chiropractic Licensing Boards (CIN-BAD), and State Disciplinary Action report will be reviewed as applicable
- Performance review of complaints, quality of care issues and utilization issues will be included in PCP recredentialing
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees

Practitioner and Provider Credentialing Right's

After the submission of the application, health care providers**:**

- Have the right to review information submitted to support their credentialing
- Have the right to correct erroneous information

- Have the right, upon request, to be informed of the status of their credentialing or recredentialing application
- Have the right to be notified within 60 calendar days of the Credentialing Committee decision
- Have the right to appeal any credentialing/recredentialing denial within 30 days of receiving written notification of the decision
- To know that all documentation and other information received for the purpose of credentialing and re-credentialing is considered confidential and is stored in a secure location that is only accessed by authorized plan associates.
- Have the right to receive notification of these rights

*To request any of the above, the Provider should contact LaCare's Credentialing Department at the following address:

Attn: Credentialing Department
LaCare Health Plan
PO BOX 83580
Baton Rouge, LA 70884

Facility Requirements

Facility Providers must meet the following criteria:

- LaCare will confirm that the facility is in good standing with all state and regulatory bodies, and has been reviewed by an accredited body as applicable
- If there is no accreditation status results, the State licensure or Medicare/Medicaid Survey will be accepted
- Re-credentialing of facilities must occur every (3) years
- The following types of facilities are credentialed and re-credentialed. LaCare maintains criteria and processes to credential and recredential the following providers:
    - Hospitals (acute care and acute rehabilitation)
    - Home health agencies/Home health hospice
    - Skilled nursing facilities
    - Skilled nursing facilities providing sub-acute services
    - Nursing homes
    - Free standing surgical centers
    - Sleep Center/Sleep Lab – Free Standing
    - Laboratory Centers
    - Infusion Agencies
    - Radiology Centers
    - Audiology, Speech, Occupational & Physical therapy Centers
    - Orthotics and Prosthetics Suppliers
    - Durable Medical Equipment Suppliers (DME)
    - Louisiana Office of Public Health (OPH) – certified School Based Health Clinics (SBHCs)
    - Rural Health Clinics (RHCs)

Facility Application

Facilities must:

- Complete the facility application with signature and current date from the appropriate facility officer
- Attest to the accuracy and completeness of the information submitted to LaCare
- Attach a current copy of the facility's unrestricted license not subject to probation, suspension, or other disciplinary action limits
- Include facility malpractice coverage and history of liability
- Attach a current copy f the accreditation certificate or letter if applicable
- Submit a Medicaid number issued by the Louisiana Medicaid Program under which service will be rendered, if required.

LaCare will:

- Verify the facility's status with state regulatory agencies through the State Department of Health
- Conduct a site visit only if no governmental agency, such as CMS, has conducted a recent onsite visit. Satisfactory survey results from the last licensure survey may be accepted in place of a site visit by LaCare
- Request information on facility sanctions prior to rendering a credentialing or recredentialing decision, by obtaining information from the Health Integrity and Protection Data Bank (HIPDB) EPLS (Excluded Parties Lists System) and HHS Office of Inspector General (OIG) (Medicare exclusions)
- Performance reviews may include a site visit from LaCare, review of complaints and quality of care issues as a requirement of recredentialing
- Maintain confidentiality of the information received for the purpose of credentialing and recredentialing
- Safeguard all credentialing and recredentialing documents, by storing them in a secure location, only accessed by authorized plan employees

*This information should be sent to LaCare's Credentialing Department at the following address:

Attn: Credentialing Department
LaCare Health Plan
PO BOX 83580
Baton Rouge, LA 70884

Member Access to Physician Information

Members can call Member Services to request information about network providers, such as where they went to medical school, where they performed their residency, and if the network provider is board-certified. Board certification status is also displayed in the online provider directory.

Provider Sanctioning Policy

It is the goal of LaCare to assure members receive quality health care services. In the event that health care services rendered to a member by a network provider represent a serious deviation from, or repeated non-compliance with, LaCare's quality standards, and/or recognized treatment patterns of the organized medical community, the network provider may be subject to LaCare's formal sanctioning process.

All sanctioning activity is strictly confidential.

Informal Resolution of Quality of Care Concerns

When a LaCare Quality Review Committee (Quality Improvement Committee, Medical Management Committee or Credentialing Committee) determines that follow-up action is necessary in response to the care and/or services begin delivered by a network provider, the Committee may first attempt to address and resolve the concern informally, depending on the nature and seriousness of the concern.

- The Chairperson of the reviewing Committee will send a letter of notification to the network provider. The letter will describe the quality concerns of the Committee, and what actions are recommended for correction of the problem. The network provider is afforded a specified, reasonable period of time appropriate to the nature of the problem. The letter will recommend an appropriate period of time within which the network provider must correct the problem

The letter is to be clearly marked:

Confidential: Product of Peer Review

Repeated non-conforming behavior will subject the network provider to a second warning letter. In addition, the network provider's member panel (if applicable) and referrals and/or admissions are frozen while the issue is investigated and monitored

Failure to conform thereafter is considered grounds for initiation of the formal sanctioning process.

Formal Sanctioning Process

In the event of a serious deviation from, or repeated non-compliance with, LaCare's quality standards, and/or recognized treatment patterns of the organized medical community, the LaCare Quality Improvement Committee or the Chief Medical Officer (CMO) may immediately initiate the formal sanctioning process.

- The network provider will receive a certified letter (return receipt requested) informing him/her of the decision to initiate the formal sanctioning process. The letter will inform the network provider of his/her right to a hearing before a hearing panel.
- The network provider's current member panel (if applicable) and referrals and/or admissions are frozen immediately during the sanctioning process.

Notice of Proposed Action to Sanction

The network provider will receive written notification by certified mail stating:

- That a professional review action has been proposed to be taken
- Reason(s) for proposed action

- That the network provider has the right to request a hearing on the proposed action
- That the network provider has 30 days within which to submit a written request for a hearing, otherwise the right to a hearing is forfeited. The network provider must submit the hearing request by certified mail, and must state what section(s) of the proposed action s/he wishes to contest
- Summary of rights in the hearing
- The network provider may waive his/her right to a hearing

Notice of Hearing

If the network provider requests a hearing in a timely manner, the network provider will be given a notice stating:

- The place, date and time of the hearing, which date shall not be less than thirty (30) days after the date of the notice
- That the network provider has the right to request postponement of the hearing, which may be granted for good cause as determined by the CMO of LaCare and/or upon the advice of LaCare's Legal Department
- A list of witnesses (if any) expected to testify at the hearing on behalf of LaCare

Conduct of the Hearing and Notice

- The hearing shall be held before a panel of individuals appointed by LaCare
- Individuals on the panel will not be in direct economic competition with the network provider involved, nor will they have participated in the initial decision to propose Sanctions
- The panel will be composed of physician members of the LaCare's Quality Committee structure, the CMO of LaCare, and other physicians and administrative persons affiliated with LaCare as deemed appropriate by the CMO of LaCare. The LaCare CMO or his/her designee serves as the hearing officer
- The right to the hearing will be forfeited if the network provider fails, without good cause, to appear

Provider's Rights at the Hearing

The network provider has the right:

- To representation by an attorney or other person of the network provider's choice
- To have a record made of the proceedings (copies of which may be obtained by the network provider upon payment of reasonable charges)
- To call, examine, and cross-examine witnesses
- To present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law
- To submit a written statement at the close of the hearing
- To receive the written recommendation(s) of the hearing panel within 15 working days of completion of the hearing, including statement of the basis for the recommendation(s)
- To receive LaCare's written decision within 60 days of the hearing, including the basis for the hearing panel's recommendation

Appeal of the Decision of the LaCare Peer Review Committee

The network provider may request an appeal after the final decision of the Panel

- The LaCare Quality Improvement Committee must receive the appeal by certified mail within 30 days of the network provider's receipt of the Committee's decision; otherwise the right to appeal is forfeited
- Written appeal will be reviewed and a decision rendered by the LaCare Quality Improvement Committee (QIC) within 45 days of receipt of the notice of the appeal

Summary Actions Permitted

The CEO, Executive Director of LaCare, the Executive Vice President and Chief Operating Officer, and/or the CMO, can take the following summary actions without a hearing:

- Suspension or restriction of clinical privileges for up to 14 days, pending an investigation to determine the need for professional review action
- Immediate revocation, in whole or in part, of panel membership or network provider status subject to subsequent notice and hearing when failure to take such action may result in imminent danger to the health and/or safety of any individual. A hearing will be held within 30 days of this action to review the basis for continuation or termination of this action

External Reporting

The CMO will direct the Credentialing Department to prepare an adverse action report for submission to the National Provider Data Bank (NPDB), the Health care Integrity and Protection Data Bank (HIPDB), and State Board of Medical or Dental Examiners if formal Sanctions are imposed for quality of care deviations and if the Sanction is to last more than 30 days, and as otherwise required by law. (NOTE: NPDB reporting is applicable only if the Sanction is for quality of care concerns.)

If Sanctions against a network provider will materially affect LaCare's ability to make available all capitated services in a timely manner, LaCare will notify all necessary parties of this issue for reporting/follow-up purposes.

Utilization Management Program

The Utilization Management (UM) program description summarizes the structure, processes and resources used to implement LaCare's programs, which were created in consideration of the unique needs of its Enrollees and the local delivery system. All departmental policies and procedures, guidelines and UM criteria are written consistent with National Committee for Quality Assurance (NCQA) accreditation standards and other applicable State and federal laws and regulations. Where standards conflict, LaCare adopts the most rigorous of the standards.

Annual Review

Annually, LaCare reviews and updates its UM and policies and procedures, as applicable. These modifications, which are approved by the LaCare Quality Assessment Performance Improvement Committee, are based on, among other things, changes in laws, regulations, requirements, accreditation requirements, industry standards and feedback from health care providers, members and others.

Scope

The LaCare Utilization Management Program establishes a process for implementing and maintaining an effective, efficient utilization management system. Utilization management activities are designed to assist the practitioner with the organization and delivery of appropriate health care services to members within the structure of their benefit plan. The LaCare UM Program promotes the continuing education of, and understanding amongst, members, participating physicians and other health care professionals.

- **Specialty Health care Referrals:** The Primary Care Practitioner (PCP) issues referrals for most outpatient specialty health care services from practitioners and providers participating in the LaCare Network. Services for Women from an OB/GYN practitioner, plain x-ray films, electrocardiograms, EPSDT screening services and services to treat an Emergency Medical Condition do not require a PCP referral or authorization from LaCare. (Authorization from LaCare is required for a referral for covered services from a practitioner or provider who does not participate with LaCare.)
- **Authorization:** LaCare utilizes an authorization process to approve coverage for select covered services for LaCare members. LaCare performs non-urgent and urgent prior (pre-service) authorization review and review of ongoing services (concurrent review) of select health care services to determine Medical Necessity and eligibility for coverage under the member's benefit package. At certain times, when information is not available to make a prior or concurrent determination and services have already been provided, member records are reviewed retrospectively to determine benefit coverage and/or medical necessity. Utilization staff may approve services based on application of LaCare's criteria. LaCare will not arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition of the member.
- **Discharge Planning:** LaCare nurses/social workers work collaboratively with staff from the Integrated Care Management programs to provide appropriate access to non-hospital based health care. Utilization Management staff work with the facility discharge planners to review and update the discharge plan, and take proactive actions to plan for discharge.

Medical Necessity Decision Making

Requests for benefit coverage or medical necessity determinations are made through staff supervised by a Registered Nurse. Decisions to approve coverage for care may be made by utilization management staff when falling within LaCare's written guidelines.

Any request that is not addressed by, or does not meet, Medical Necessity guidelines is referred to the Medical Director or designee for a decision. Any decision to deny, alter or limit coverage for an admission, service, procedure or extension of stay, based on Medical Necessity, or to approve a service in an amount, duration or scope that is less than requested is made by a Medical Director or other designated practitioner under the clinical direction of the Regional Medical Director.

Medical Necessity decisions made by a Medical Director are based on the Department of Health and Hospital's definition of Medical Necessity [as defined in LAC 50:1.101 (Louisiana Register, Volume 37, Number 1)], in conjunction with the member's benefits, medical expertise, LaCare Medical Necessity guidelines, and/or published peer-review literature. At the discretion of the Medical Director, participating board-certified physicians from an appropriate specialty or other

qualified health care professionals may provide input to the decision. The Medical Director makes the final decision.

LaCare will not retroactively deny reimbursement for a covered service provided to an eligible member by a provider who relied on written or oral authorization from LaCare or an agent of LaCare, unless there was material misrepresentation or fraud in obtaining the authorization.

LaCare will provide its Utilization Management (UM) criteria to network providers upon request. To obtain a copy of LaCare UM criteria:

- Call the UM Department at **888-913-0350**
- Identify the specific criteria you are requesting
- Provide a fax number or mailing address

You will receive a faxed copy of the requested criteria within 24 hours or written copy by mail within five business days of your request.

Please remember that LaCare has Medical Directors and Physician Advisors who are available to address UM issues or answer your questions regarding decisions relating to Prior Authorization, DME, Home Health Care and Concurrent Review. Call the Medical Director Hotline at: 866-935-0251.

Additionally, LaCare would like to remind health care providers of our affirmation statement regarding incentives:

- Utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage;
- Providers, associates or other individuals conducting utilization review are not rewarded by the [LaCare] for issuing denials of coverage or service; and
- Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Clinical Practice Guidelines (PENDING MULTI PLAN AGREEMENT)

LaCare has adopted clinical practice guidelines for use in guiding the treatment of members, with the goal of reducing unnecessary variations in care. The clinical practice guidelines represent current professional standards, supported by scientific evidence and research. These guidelines are intended to inform, not replace, the physician's clinical judgment. The physician remains responsible for ultimately determining the applicable treatment for each individual.

The following complete clinical practice guidelines are available upon request by calling the Provider Services Department or by visiting the Provider Center of our website at www.lacarelouisiana.com.

Asthma	Sickle Cell
Chlamydia	Hypertension
Chronic Obstructive Pulmonary Disease	EPSDT
Diabetes	Preventive Health Guidelines
Heart Failure	Maternity

Hours of Operation

LaCare provides and maintains a toll free number for health care providers, and members to contact LaCare's UM staff. The toll free number is **888-913-0350**. LaCare's UM Department is available to answer calls from health care providers and members during normal business hours, 8:30 a.m.-5:00 pm. Translation services are available as needed.

After business hours and on weekends and holidays, health care providers and members are instructed to contact the On-Call Nurse through the LaCare's Member Services number **888-756-0004**. After obtaining key contact and member information, the Member Service Representative pages the on-call Nurse. The on-call Nurse contacts the Health Care Provider or member, as needed, to acquire the information necessary to process the request. The on-call Nurse will call the on-call Physician Reviewer to review the request, if necessary. The on-call Nurse is responsible to contact the requesting Health Care Provider or member with the outcome of their request.

Timeliness of UM decisions

Several external standards guide LaCare's timeline standards. These include NCQA, Local requirements and accompanying regulations, and other applicable state and federal laws and regulations. When standards conflict, LaCare adopts the more rigorous of the standards. Table 1 identifies LaCare's timeliness standards.

Table 1: Timeliness Of UM Decisions

Case Type	Decision	Initial Notification	Written Confirmation
Urgent Prior Authorization	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request	As expeditiously as the member's health requires, no later than 72 hours from receipt of the request	Within the earlier of 2 business days from the decision or 72 hours of the request
Non-Urgent Prior Authorization	Within 2 days of receiving the necessary information or 14 calendar days from receipt of the request *	As expeditiously as the member's health requires, no later than 1 business day of making the decision	Within the earlier of 2 business days from the decision or 15 calendar days of the request
Concurrent Review	Within 24 hours from receipt of the request*	Within 24 hours from receipt of the request	Within 24 hours of the initial notification
Retrospective Review	30 calendar days from receipt of the request; no later than 180 days from the date of service	Not Applicable	Within 30 calendar days from receipt of the request

* The timeframes for decisions and notification may be extended if additional information is needed to process the request. In these instances, the member and requesting Health Care Provider are notified of the required information in writing.

Physician Reviewer Availability to Discuss Decision

If a practitioner wishes to discuss a medical necessity decision, LaCare's physician reviewers are available to discuss the decision with the practitioner. A call to discuss the determination is accepted from the Practitioner:

- At anytime while the member is an inpatient
- Up to 48 hours or the end of the second (2nd) business day after the member's discharge date, whichever is later
- Up to 48 hours after a determination for a Prior (Pre-Service) request has been rendered
- Up to 48 hours or until the end of the second (2nd) business day after a determination of a retrospective review has been rendered, whichever is later.

A dedicated reconsideration line with a toll-free number has been established for practitioners to call at 866-935-0251. A physician reviewer is available at any time during the business day to interface with practitioners. If a practitioner is not satisfied with the outcome of the discussion with the physician reviewer, then the practitioner may file a Formal Provider Appeal of a Medical Necessity Decision, please see Section X. For information on the types of issues that may be the subject of a Formal Provider Appeal, please see Section V.

Denial Reasons

All denial letters include specific reasons for the denial, the rationale for the denial and a summary of the UM criteria. In addition, if a different level of care is approved, the clinical rationale is also provided. These letters incorporate a combination of NCQA standards, requirements and Department of Health requirements. Denial letters are available in six languages for members with Limited English Proficiency. Letters are translated into other languages upon request. This service is available through the cooperation of Member Services and Utilization Management.

Appeal Process

All denial letters include an explanation of the member's rights to appeal and the processes for filing appeals through the LaCare Medical Necessity Appeal Process and the Fair Hearing Process. Members contact the Member Service Unit to file Grievances or Appeals where a member advocate is available to assist members as needed.

Evaluation of New Technology

When LaCare receives a request for new or emerging technology, it compiles clinical information related to the request and reviews available evidence-based research and/or technology assessment group guidelines. LaCare Medical Directors make the final determination on coverage.

Evaluation of Member & Provider Satisfaction and Program Effectiveness

Annually, the UM department completes an analysis of member and network provider satisfaction with the UM Program. At a minimum, the sources of data used in the evaluation include the annual member satisfaction survey results, member complaint and grievance data, Provider satisfaction survey results, and Provider complaint and appeal data;.

To support its objective to create partnerships with physicians, LaCare actively seeks information about network provider satisfaction with its programs on an ongoing basis. In addition to

monitoring Health Care Provider complaints, LaCare holds meetings with network providers to understand ways to improve the program.

Monthly, the department reports telephone answering response, abandonment rates and decision time frames.

Section VIII
Special Needs & Case Management

Integrated Care Management (Health Education and Management)

LaCare's Integrated Care Management (ICM) program is a holistic solution that uses a population-based health management program to provide comprehensive care management services. This fully integrated model allows members to move seamlessly from one component to another, depending on their unique needs. There are five core components to our Integrated Care Management (ICM) program: Pediatric Preventive Health Care, Episodic Care Management, WeeCare (Maternity Management), Complex Care Management (CCM), and Rapid Response. Each of these is summarized below.

Pediatric Preventive Health Care

The Pediatric Preventive Health Care Program (PPHC) is designed to improve the health of members under age 21 by increasing adherence to KIDMED/Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program guidelines. We accomplish this by identifying and coordinating preventive services for these members. The PPHC combines scheduled written and telephonic outreach with state-of-the art informatics that provides point-of-contact notification of EPSDT needs to employees and providers. Additional information on this program and coverage for EPSDT Services can be found in Section IV.

Episodic Care Management

The Episodic Care Management (ECM) program coordinates services for members with short-term and/or intermittent needs who have single problem issues and/or co-morbidities. The Care Manager supports members in the resolution of pharmacy, DME and/or dental access issues, transportation needs, identification of and access to specialists, or referral and coordination with behavioral health providers or other community resources. Care Managers perform comprehensive assessments, address short-term and long-term goals, and develop a plan of care with input from the member and the physician(s). The ECM team has both RN and MSW Care Managers.

WeeCare (Maternity Management)

Described more fully below, the WeeCare (maternity) Program is managed by a dedicated team of Care Managers and Care Connectors. The WeeCare team outreaches to pregnant members and engages them into the program based on internal and external assessments that stratify them into high- and low-risk categories. Care Managers coordinate care and address various issues throughout the member's pregnancy and post-partum period, including dental screenings and depression screenings. Members assessed as low-risk receive information via mailings with access to a Care Manager as necessary. Members identified as high-risk are managed by the plan with a team of both Care Managers and Care Connectors.

Complex Care Management

Members identified for Complex Care Management (CCM) receive comprehensive and disease-specific assessments, and reassessments, along with the development of short-term and long-term goals and an individual plan of care, created with input from the member/caregiver and the physician(s). The CCM process includes reassessing and adjusting the care plan and its goals as needed. Care Connectors are assigned tasks to assist the member with various interventions under the direct supervision of the Care Manager. Care Managers coordinate care and address

various issues including but not limited to: pharmacy, DME and/or dental access, assistance with transportation, identification of and access to specialists and referral and coordination with behavioral health providers or other community resources. The Complex Care Management team contains both nurse and social worker Care Managers.

Rapid Response Team

An important component of the ICM model, the Rapid Response (RR) team was developed to address the urgent needs of our members and to support our providers and their staff. The RR team consists of registered nurses, social workers, and non-clinical Care Connectors.

There are three key service functions performed in the RR unit:

- **Inbound Call Service –** Members and providers may request RR support via a direct, toll-free Rapid Response line. Providers can call the Rapid Response team for assistance coordinating care for members in their office; to request assistance for members who need community resources or to refer a member for any care management service.
- **Outreach Service –** Outreach activities include telephonic survey or assessment completion and support of special projects or quality initiatives. RR employees also initiate follow-up calls to members recently discharged from the hospital and members who contacted the 24-hour Nurse Line the previous day.
- **Care Management Support –** Care Connectors support Care Managers by completing tasks and reminder calls in support of the individualized plan of care. These include appointment scheduling and reminders, transportation support, member educational mailings, and other administrative tasks assigned by Care Managers.

Several services overlap all five core components. Each component includes targeted interventions for special needs populations, EPSDT-eligible populations and members with chronic conditions.

Special Needs

LaCare uses several methods to identify members with special health needs, including data analysis, new member surveys and referral triggers. Our processes focus on identification of conditions that require ongoing management, such as chronic illness, and specific services, including home health care, therapy, and equipment or oxygen rental, that may indicate an ongoing course of treatment or complex needs.

Diagnoses	Services	Provider Types
Pregnancy Asthma Autism Cardiac Artery Disease Chronic Obstructive Pulmonary Disease Depression Diabetes Heart Failure	Cancer Treatment (chemotherapy or radiation therapy) Home Health Care Oxygen DME rental Therapy Dialysis	Home Health Agency DME Company Transportation Dialysis Facility Hospice

Diagnoses	Services	Provider Types
HIV/AIDS Sickle Cell Anemia		

Providers are encouraged to refer members with Special Health Needs to the Rapid Response team for triaging into one of our care management programs. The Rapid Response Team can be reached by calling **888-922-0007**.

WeeCare Program for Pregnant Members

LaCare has developed a comprehensive prenatal risk reduction program in an effort to decrease the poor obstetrical outcomes of our pregnant population, which were evidenced by the following:

- High percentage of low birth-weight infants
- Infant readmission rates
- Rising preterm births
- Increased incidents of maternal complication requiring extended hospitalizations

The goals of the WeeCare Program are:

- Early identification of pregnant members
- Early and continued intervention throughout pregnancy
- Education and follow-up to promote recommended infant care

LaCare utilizes several means to identify members as early in their pregnancy as possible. These include but are not limited to claim data analysis, information from the initial health assessment, referrals from internal LaCare Departments, the use of member newsletters and referral networks, and physician referrals. Members who agree to participate in the WeeCare Program are paired with a LaCare WeeCare Care Manager. The WeeCare Care Manager works closely with the member, assuring that she has the means necessary to receive prenatal instruction and respond to various social and medical needs. WeeCare Case Managers offer the following types of special services to our WeeCare members:

- Counseling
- Home Visits (as needed)
- Health Education
- Connection to social support services

Members may refer themselves to the participating OB/GYN specialist of choice for maternity care services, including the initial visit.

WeeCare separates pregnant members into low and high intensity risk categories:

- Low Risk Pregnancy Management - Members receive pregnancy-related educational materials encouraging good prenatal care
- High Risk Pregnancy Management - Pregnant members identified at risk for preterm labor and/or other pregnancy complications re assigned a Nurse Care Manager to provide ongoing

supervision and education concerning pregnancy. A letter is sent to the member's physician to notify him/her of the member's enrollment in the program with a summary of the initial assessment

All pregnant members have access to a 24-hour toll free registered nurse call line at **1-866-431-1514**.

All pregnant members are encouraged to select a pediatrician prior to delivery.

For more information or to refer members to the WeeCare Program call 888-913-0327

- To request Care Management Services for pregnant members
- For questions on WeeCare Program specific policies and procedures
- To request home care services for pregnant members

Pediatric Preventive Health Care Program

Known as KIDMED/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The goal of the Pediatric Preventive Health Care (PPHC) Program is to improve the health of members under age 21 by increasing adherence to KIDMED and National Immunization Program guidelines. The PPHC program focuses on identification and coordination of preventive services for members under age 21.

The program is structured to provide assessment of the member's condition and monitoring of adherence to pediatric preventive guidelines, along with consideration of the member's other health conditions and lifestyle issues. The PPHC Program provides a mechanism to ensure that members under age 21 receive screening, preventive care and related medical services required by the EPSDT program. By state and federal mandate, EPSDT requirements include: well child visits, immunizations, lead screening, dental services, vision screening, hearing screening, anemia screening, urinalysis, Sickle Cell Disease screening and screening for Sexually Transmitted Diseases (STDs). Members are considered enrolled upon identification, unless the member or parent/guardian notifies LaCare to remove the member from the program. Upon enrollment, eligible members receive program materials explaining how to use the program, available services, how members are selected to participate and how to opt-out of the program.

Detailed information about LaCare’s EPSDT requirements for physicians can be found in Section IV Referral and Authorization Requirements and Policies.

Chronic Condition Management Programs

LaCare offers several Chronic Condition Management Programs designed to support a network provider's plan of care for patients with the following diseases:

Asthma	Heart Failure
COPD	CAD
Diabetes	Sickle Cell Disease

Members will receive educational materials and if identified as high risk will be assigned to a Care Manager for one-on-one education and follow-up. **For more information or to refer a patient, call 888-922-0007**.

Outreach & Health Education Programs

The goal of LaCare's Health Education Programs is to increase members' knowledge of self-management skills for selected disease conditions. These health education programs focus on prevention in order to help members improve their quality of life. The LaCare Community Education Department works in collaboration with Outreach and Rapid Response units to achieve desired outcomes.

Tobacco Cessation

The tobacco cessation program offers members a series of educational classes easily accessible within their communities. The program offers targeted outreach to members who are pregnant or who have chronic conditions such as asthma, diabetes, cardiovascular disease or other serious medical conditions, encouraging these members to enroll in tobacco cessation classes. For more information go to the Louisiana Tobacco Control Program website: www.latobaccocontrol.com.

Gift of Life

The Gift of Life is an outreach program developed to increase members' awareness of the importance of a mammography screening and to encourage female members age 50 and older to have regularly scheduled mammograms. LaCare establishes partnerships with community organizations. Designated outreach staff contacts members by phone or mail, to schedule mammography screenings, remind LaCare members of appointments, and reschedule appointments if necessary. All results are sent to the PCP for follow-up.

Domestic Violence Intervention

There has been a growing recognition among health care professionals that domestic violence is a highly prevalent public health problem with devastating effects on individuals and families. Health care providers can play an important role in identifying domestic violence. Routine screening for domestic violence increases the opportunity for effective intervention and enables health care providers to assist their patients, and family members who are victims.

-

Louisiana has many resources for domestic violence victims and their family members.

Domestic Violence Resource	Contact Information
Louisiana Coalition Against Domestic Violence	State-wide Domestic Violence Hotline: 1-888-411-1333 www.lcadv.org
National Domestic Violence Hotline	1-800-799-SAFE (7233) www.thehotline.org
Louisiana Foundation Against Sexual Assault	www.lafasa.org

Domestic Violence Advocates and Support Contacts (An Abuse, Rape and Domestic Violence Resource Collection)	Louisiana specific information: www.aardvarc.org/dv/sttes/ladv.shtml

For more information, visit the Provider Center at www.lacarelouisiana.com. See Appendix 22 in this manual for the National Coalition Against Domestic Violence Fact Sheet.

The Provider's Role

Network providers can help to identify and refer members who are at high risk for particular diseases and disorders to the appropriate program.

Call the Rapid Response Team at 888-922-0007:

- With questions about any of the health education programs
- With requests for outreach services

Early Steps (Early Intervention System)

Louisiana's Early Intervention is a collection of services and supports that help families to enhance their skills in raising a child with disabilities and are covered through the. Louisiana's Early Steps Program. LaCare will help coordinate services and access to early intervention programs.

Early Steps provides services to families with infants and toddlers aged birth to three years (36 months) who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. Early Steps services are designed to improve the family's capacity to enhance their child's development. These services are provided in the child's natural environment, such as the child's home, child care or any other community setting typical for children aged birth to 3 years (36 months).

When a child turns three years of age, the responsibility for funding Early Intervention services is an education expense. Children may remain eligible for Early Intervention services through the minimum age at which a child can attend first grade in his/her own school district.

An infant or toddler (birth to three years of age) is eligible for Early Intervention Services if he/she:

- Shows a significant delay in one or more areas of child development
- Has a physical disability, a hearing or vision loss
- Receives a specialist's determination that a delay exists even though it is not evident on evaluations (called informed clinical opinion)
- Has a known physical or mental condition with a high probability for developmental delay (Down Syndrome is one example)

If an infant or toddler is found not to be eligible for Early Intervention, he/she may still be eligible for follow-up tracking in the event the needs of the child and family change.

Children eligible for tracking are:

- Born weighing less than 3 ½ pounds
- Cared for in a neonatal intensive care unit
- Born to mothers who are chemically addicted
- Found to have blood lead levels at 15 micrograms per deciliter and above

The services provided to eligible children and their families are individualized in accordance with the developmental needs of each child. Early Intervention supports may include a range of informal and formal opportunities, experiences and resources found in each family's community. Services may be provided in the child's home, childcare center, nursery school, playgroup, or other community settings where the child would be found if he or she did not have a disability.

Families with concerns about their child's development should consult their family network provider. If parents have continuing concerns, or want additional information, please go to the Early Steps website: http://new.dhh.louisiana.gov/index.cfm/page/139/n/139.

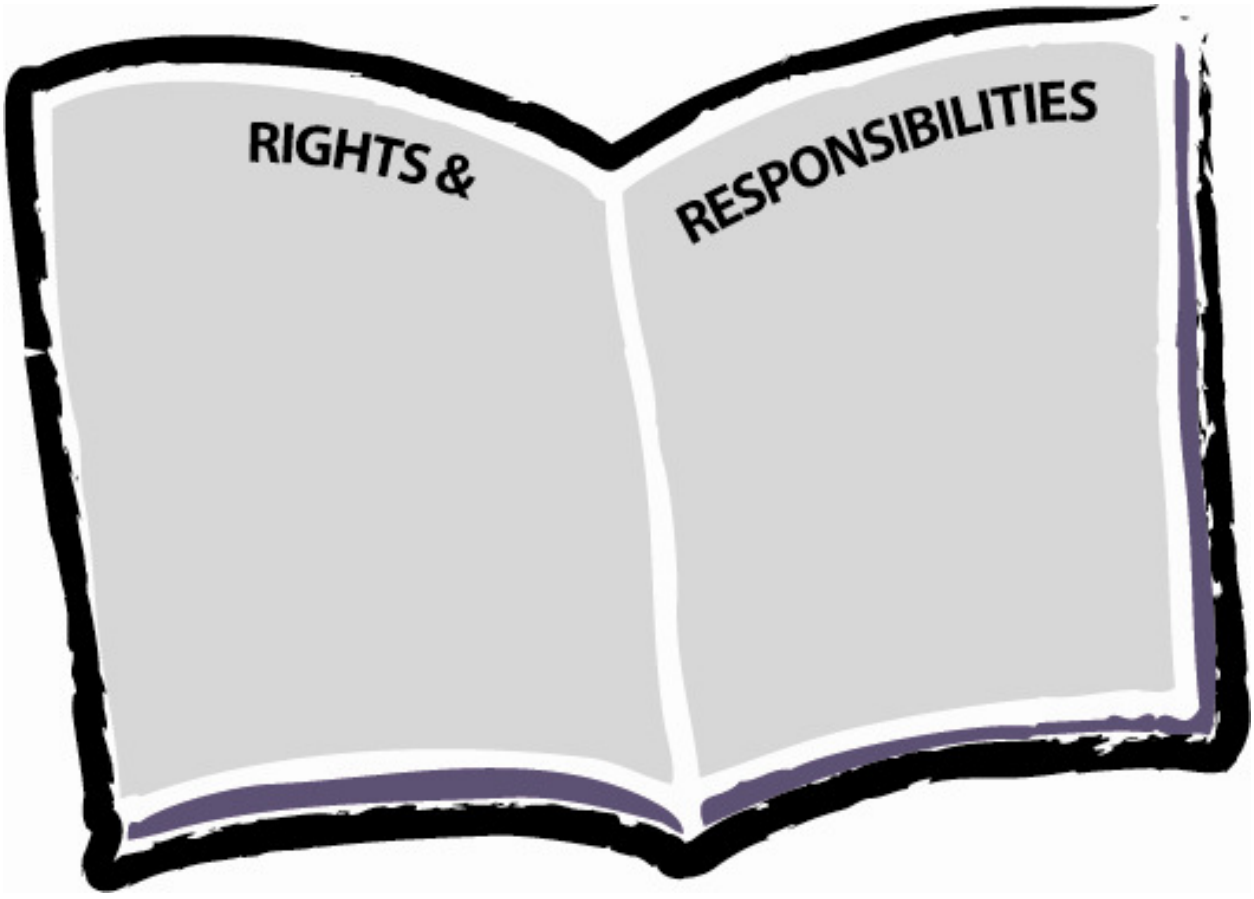
Referrals to Early Intervention are directed to the System Point of Entry Office in the region of Louisiana where the family resides. Initial contact with the referred family occurs locally at a time and place convenient to the family. A screening at no-cost to the family will be offered to determine if the child shows any areas of delay. Further evaluations may determine eligibility for Early Intervention services or follow-up tracking.

Specialists as PCPs for Special Needs Members

Specialists may be able to serve as PCPs for Special Needs Members, including members that have a disease or condition that is life threatening, degenerative, or disabling. LaCare members may contact the Rapid Response Team to request approval to utilize a specialist as PCP. Care Managers will work with the member and LaCare staff to identify an appropriate Specialist. The Specialist must have expertise in the treatment of the medical condition of the member.

To accommodate these members, LaCare's Care Management staff will contact the requested Specialist and obtain their verbal agreement to provide specialty care services, as well as, primary care services. The Specialist will be informed that the final approval is subject to meeting credentialing requirements and office accessibility standards (including EPSDT requirements). Upon approval, this information will be forwarded to Provider Network Development and Member Services Departments. LaCare's Provider Network Development Department will negotiate a contract with specialists who meet LaCare's Credentialing criteria, and who wish to function as a PCP for a member(s) with Special Needs. The specialist will be set-up in our Provider Network database as a "Specialist as PCP". The member will then be assigned to the "Specialist as PCP" panel.

Section IX
Member Rights and Responsibilities



Member Rights & Responsibilities

LaCare is committed to treating our members with respect. LaCare, its network providers, and other Providers of service, may not discriminate against members based on race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated.

Member Rights

Louisiana Medicaid Coordinated Care Network Program Member's and Potential Member's Bill of Rights

Each member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information — e.g., enrollment notices, informational materials, instructional materials, available treatment options and alternatives — in a manner and format that may be easily understood as defined in the Contract between DHH and LaCare.
- To receive assistance from both DHH and the Enrollment Broker in understanding the
- requirements and benefits of LaCare.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of LaCare
- program; which populations may or may not enroll in the program, and LaCare's
- responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the LaCare's services, to include, but not limited to:
    - Benefits covered
    - Procedures for obtaining benefits, including any authorization requirements
    - Any cost sharing requirements
    - Service area
    - Names, locations, telephone numbers of and non-English language spoken by
    - current contracted providers, including at a minimum, primary care physicians,
    - specialists, and hospitals

  - Any restrictions on member's freedom of choice among network providers
  - Providers not accepting new patients
  - Benefits not offered by the LaCare but available to members and how to obtain
  - those benefits, including how transportation is provided
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in core benefits and services at least 30 days
- before the intended effective date of the change.
- To receive information on grievance, appeal and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services, and
  - post-stabilization services
  - That emergency services do not require prior authorization
  - The process and procedures for obtaining emergency services
  - The locations of any emergency settings and other locations at which providers
  - and hospitals furnish emergency services and post-stabilization services
  - covered under the contract
  - Member's right to use any hospital or other setting for emergency care
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c)
- To receive the LaCare's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way LaCare, its providers or DHH treat the member.

Member Responsibilities

Members have the responsibility to inform LaCare and its network providers of any changes in eligibility, or any other information that may affect their membership, health care needs or access to benefits. Some examples include, but are not limited to the following:

- Pregnancy
- Birth of a baby
- Change in address or phone number
- A member or a member's child is covered by another health plan
- Special medical concerns
- Change in family size
- Loss or theft of LaCare ID Card

Members have the responsibility to cooperate with LaCare and its network providers. This includes:

- Following network provider instructions regarding care
- Making appointments with their PCP
- Canceling appointments when they cannot attend
- Calling LaCare when they have questions

- Keeping their benefits up to date with the case worker. Finding out when their benefits will end and making sure that all demographic information is up to date to keep their benefits.
- Understanding their health problems and working with their provider to set goals for their treatment, to the degree they are able to do so

Members have the responsibility to treat their network provider and the network provider's staff with respect and dignity.

Patient Self-Determination Act

The Patient Self-Determination Act is a Federal law that states competent adults have the right to choose medical care and treatment. A member has the right to make these wishes known to his/her PCP and other Providers as to whether he/she would accept, reject or discontinue care under certain circumstances.

A member should prepare an advance directive to maintain his/her rights in a situation where he/she may not be able to tell his/her Health Care Provider what is/is not wanted. Once the member has prepared an advance directive, a copy should be given to his/her PCP. The Health Care Provider should be aware of and maintain in the member's medical record a copy of the member's completed advance directive. Members are not required to initiate an advance directive or proxy and cannot be denied care if they do not have an advance directive.

An **Advance Directive** is only used when the member is not able to make decisions about his/her treatment, such as if the member is in a coma.

The member's rights under Louisiana state law, include the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives.

PCPs should be aware of, and discuss, the Patient Self-Determination Act with their adult patients. Specific responsibilities of the PCP are:

- Discuss the patient's wishes regarding advance directives on care and treatment during routine and/or episodic office visits when appropriate
- Document the discussion in the patient's medical record and whether or not the patient has executed an advance directive
- Provide the patient with written information concerning advance directives if asked.
- Do not discriminate against the individual based on whether or not she/he has executed an advance directive.
- Ensure compliance with the requirements concerning advance directives

LaCare provides our members with information about the Patient Self-Determination Act via the Member Handbook including their right to file complaints about failure to comply with an advance directive with Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138.

Section X
Provider Medical Necessity Appeals
Member Appeals, Complaints & Grievances

Provider Medical Necessity Appeals

Both Network and Non-Participating Providers may request formal resolution of an appeal of a medically necessary decision through LaCare's Formal Provider Appeals Process OR they may appeal on behalf a member following the Member Grievance and Appeal process (which follows the Provider Appeals Section.) . Providers cannot appeal through both processes.

Formal Provider Appeals Process

This process consists of two levels of review and is described in greater detail below.

What is an Appeal?
An appeal is a written request from a Health Care Provider for the reversal of an action which is defined as:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner (as defined by DHH), and
- The failure of the CCN to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR §438.400(b);

Examples of appeals include, but are not limited to:

- Member is admitted to the hospital as a result of an Emergency Room visit. The inpatient stay is for a total of fifteen (15) hours. The hospital provider submits a Claim for reimbursement at the one-day acute inpatient rate but LaCare reimburses at the observation rate, in accordance with the hospital's contract with LaCare.

Types of issues that may not be appealed through LaCare's Formal Provider Appeals Process are:

- Claims denied by LaCare because they were not filed within LaCare's 356-day filing time limit; Claims denied for exceeding the 365-day filing time limit may be appealed through the Claims Dispute process outlined in this Manual.
- Denials issued as a result of a Prior (pre-service) Authorization review by LaCare (the review occurs prior to the member being admitted to a hospital or beginning a course of treatment); denials issued as a result of a Prior Authorization review may be appealed by the member, or the Health Care Provider, with written consent of the member, through LaCare's Member Complaint and Grievance Process outlined in the Section titled Complaints, Grievances and Fair Hearings for members.
- Provider terminations based on reasons related to quality of care may be appealed in accordance with the LaCare Provider Sanctioning Policy outlined in Section VIII; and credentialing/recredentialing denials may be appealed as provided in the credentialing/recredentialing requirements outlined in Section VIII.

First Level Appeal Review

Filing a Request for a First Level Appeal Review

Health care providers may request a First Level Appeal review by submitting the request in writing within 30 calendar days of: the date of the denial or adverse action by LaCare or the member's discharge, whichever is later. The request must be accompanied by all relevant documentation the Health Care Provider would like LaCare to consider during the First Level Appeal review.

Requests for a First Level Appeal Review should be mailed to the appropriate Post Office Box below and must contain the words "First Level Outpatient Formal Provider Appeal", or "First Level Inpatient Formal Provider Appeal", as appropriate at the top of the request:

First Level Appeal:

Provider Appeals Department
LaCare Health Plan
P.O. Box 7324
London, KY 40742

Second Level Appeal:

Provider Appeals Department
LaCare Health Plan
P.O. Box 7324
London, KY 40742

LaCare will send the Health Care Provider a letter acknowledging LaCare's receipt of the request for a First Level Appeal Review within seven (7) calendar days of LaCare's receipt of the request from the Health Care Provider.

Physician Review of a First Level Appeal

The First Level Appeal Review is conducted by a Medical Director or physician designee who was not involved in the decision making for the original denial or prior reconsideration of the case. The Medical Director or physician designee will issue a determination to uphold, modify or overturn the denial based on:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
    - LaCare medical and administrative policies
    - Information submitted by the Health Care Provider or obtained by LaCare through investigation
    - The network provider's contract with LaCare
    - LaCare's contract with the State of Louisiana's Medicaid Program and relevant Medicaid laws, regulations and rules

Time Frame for Resolution of a First Level Appeal

Health care providers will be notified in writing of the determination of the First Level Appeal review, including the clinical rationale, within 30 calendar days of LaCare's receipt of the Health Care Provider's request for the First Level Appeal review. If the Health Care Provider is dissatisfied with the outcome of the First Level Appeal review, the Health Care Provider may request a Second Level Appeal review. See the "Second Level Appeal Review" topic in this Section of the Manual.

Second Level Appeal Review

Filing a Request for a Second Level Appeal Review

Health care providers may request a Second Level Appeal by submitting the request in writing within thirty (30) calendar days of the date of LaCare's First Level Appeal determination letter. The request for a Second Level Appeal Review must be accompanied by any additional information relevant to the Appeal that the Health Care Provider would like LaCare to consider during the Second Level Appeal Review. Requests for a Second Level Appeal Review of an Appeal should be mailed to the appropriate Post Office Box below and must contain the words "Second Level Outpatient Formal Provider Appeal" or "Second Level Inpatient Formal Provider Appeal", as appropriate, at the top of the request.

First Level Appeal:

Provider Appeals Department
LaCare Health Plan
P.O. Box 7324
London, KY 40742

Second Level Appeal:

Provider Appeals Department
LaCare Health Plan
P.O. Box 7324
London, KY 40742

LaCare will send the Health Care Provider a letter acknowledging LaCare's receipt of the request for a Second Level Appeal Review within seven (7) calendar days of LaCare's receipt of the request from the Health Care Provider.

Appeal Panel Review of a Second Level Appeal

A Medical Director or physician designee, who was not involved in the decision-making for the original denial, or prior appeal review of the case, will review the appeal. The Medical Director or physician designee will issue a recommendation, including the clinical rationale, to LaCare's Appeal Panel to uphold, overturn or modify the denial based upon clinical judgment, established standards of medical practice, and review of LaCare medical and administrative policies, available information submitted by the Health Care Provider or obtained by LaCare through investigation, the Health Care Provider's contract with LaCare, LaCare's contract the Louisiana Medicaid Program and relevant Medicaid laws, regulations and rules. The Medical Director or physician designee's recommendation will be provided to the Appeal Panel for consideration and deliberation.

At the request of the Appeal Panel, the Reviewing Physician may present his/her recommendation in person at the Appeal Panel meeting. The panel is comprised of at least three individuals, including one Physician Reviewer in current practice contracted by LaCare but not employed with LaCare (peer representative) and two other management staff from LaCare's Provider Network Management, Provider Appeal, or Claim Departments.

The Appeal Panel will issue a determination including clinical rationale, to uphold, modify, or overturn the original determination based upon:

- Clinical judgment
- Established standards of medical practice
- Review of available information including but not limited to:
    - LaCare medical and administrative policies

- Information submitted by the Provider or obtained by LaCare through investigation
- The Provider's contract with LaCare
- Relevant Medicaid laws, regulations and rules

Time Frame for Resolution

Health care providers will be notified in writing of the determination of the Second Level Appeal Review within 30 calendar days of LaCare's receipt of the Health Care Provider's request for a Second Level Appeal Review.

Providers may also file an appeal on behalf of a member following the Member Grievance and Appeals Process that follows. Providers can only follow **one appeal process.** If the provider files an internal appeal with LaCare he or she may not also follow the Member Grievance and Appeal Process.

Member Grievance and Appeal Process

The following is a description of the process.

Grievance Procedures

Grievance – An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

To file a grievance on behalf of a member, call Member Services at **1-888-756-0004**. Should the member, or provider filing on behalf of a member, need assistance, LaCare staff is trained to assist the member or provider including documenting the grievance. The provider can also, with the members consent, write to us at:

LaCare
Member Services Supervisor
P.O. box 7322
London, KY 40743

An acknowledgement letter to the member (with a copy to the provider filing on behalf of the member) will be mailed within 1 business day of when our receipt of the receive your grievance.

Providers may follow the processes below by filing on behalf of the member and with the member's written consent. LaCare recommends that the written consent contain the following elements:

The consent document giving the health care provider authority to pursue a Grievance on behalf of a member should include each of the following elements:

- The name and address of the member, the member's date of birth, and the
- Member's identification number.

- If the member is a minor, or is legally incompetent, the name, address and relationship to the member of the person who signs the consent for the member.
- The name, address and identification number of the health care provider to whom the member is providing the consent.
- The name and address of the plan to which the Grievance will be submitted
- An explanation of the specific service for which coverage was provided or denied to the member to which the consent will apply.
- The following statements:
    - The consent of the Member or the Member's legal representative is automatically rescinded if the Health Care Provider fails to file a Grievance, or fails to continue to prosecute the Grievance through the Second Level Review Process.
    - The Member or the Member's legal representative, if the Member is a minor or is legally incompetent, has read, or has been read this consent form, and has had it explained to his/her satisfaction. The member, or the member's legal representative understands the information in the Member's consent form.
- The consent document must also have the dated signature of the Member, or the Member's legal representative if the Member is a minor or is legally incompetent. A sample Member Consent form can be found as Appendix 21.

Standard Grievance

Members, or Providers filing on their behalf, may file a Grievance within thirty (30) days from the date of the incident complained of or the date the member receives written notice of the decision if the Grievance.

The Grievance Review Committee performs the review. The committee is composed of one or more employees of LaCare who were not involved in any previous level of review or decision-making on the issue that is the subject of the Grievance. For Grievances involving clinical issues, the Grievance Review Committee shall include a licensed physician. The physician on the committee decides the Grievance. The committee receives a written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question.

The Grievance Review Committee completes its review of the Grievance as expeditiously as the member's health condition requires, but no more than ninety (90) (days from receipt of the Grievance, which may be extended by fourteen (14) days at the request of the member if the Complaint involves any of the issues listed in items (a)-(e) in this document's definition of the term "Grievance."

LaCare sends a written notice of the Grievance decision to the member and other appropriate parties within five (5) business days from the decision, but not later than ninety (90) days from receipt of the Grievance by LaCare, unless a fourteen (14) day extension was granted, in which case

The member or member representative may file a request for a Fair Hearing within thirty (30) days from the mail date on the written notice of the Grievance decision if the Grievance disputes the failure to provide a service/item, or to decide an Appeal within specified time frames, or disputes a denial made for the reason that a service/item is not a covered benefit or disputes a

denial of payment after a service(s) has been delivered because the service/item provided is not a covered benefit for the member. Fair Hearing Procedures are outlined further in this section.

Appeal Procedures

Standard First Level Appeals

An appeal is a request for a review of an **Action** pursuant to 42 CFR §438.400(b) which is: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service, the failure to provide services in a timely manner (as defined by DHH), and the failure of the CCN to act within the timeframes for the resolution of grievances and appeals as described in 42 CFR §438.400(b); and in a rural area with only one CCN, the denial of a member's right to obtain services outside the provider network, as described in §438.52(b)(2)(ii).

A provider with a member's consent may file an appeal. An appeal must be in writing. LaCare must receive the appeal within 30 calendar days of t he date of the decision letter. LaCare staff is trained to assist members or providers filing on behalf of a member with the appeal documentation. Member Services can be reached by calling **1-888-756-0004**.

The written appeal should be sent to:

Appeals Coordinator
LaCare
P.O. box 7324
London, KY 40743

An acknowledgement letter will be mailed within 1 business day of when we receive the appeal. The letter will acknowledge receipt of the appeal and contain the date and time we will review the appeal.

Members have thirty (30) days from the date the member receives the written notice of denial to file an Appeal. Upon receipt of the Appeal, LaCare sends the member and provider an acknowledgement letter.

If a first level Appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, the member continues to receive the disputed service/item at the previously authorized level pending resolution of the first level Appeal, if the first level Appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision. LaCare also honors a verbal filing of a first level Appeal within ten (10) days of receipt of the written denial decision in order to continue services.

The first level Appeal review is performed by the First Level Appeal Review Committee, which includes one or more employees of LaCare, including a licensed physician, who was not involved in any previous level of review or decision-making on the subject of the Appeal. The committee receives a written report from a licensed physician or other appropriate provider in the

same or similar specialty that typically manages or consults on the service/item in question. The physician on the committee decides the Appeal.

The First Level Appeal Review Committee completes its review of the Appeal as expeditiously as the member's health condition requires, but no more than thirty (30) days from receipt of the Appeal, which may be extended by fourteen (14) days at the request of the member.

LaCare sends a written notice of the first level Appeal decision to the member and other appropriate parties within five (5) business days of the committee's decision, but not later than thirty (30) days from receipt of the Appeal by LaCare, unless a fourteen (14) day extension was granted. The written notice of the resolution includes the following: The results of the resolution process and the date it was completed.. For appeals not resolved wholly in favor of the members: The right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the LaCare's action.

Standard Second Level Appeals

The member or provider on behalf of the member may file a request for a second level Appeal review within thirty (30) days of the date the member receives the written notice of LaCare's first level Appeal decision.

Upon receipt of the second level Appeal, LaCare sends the member and other appropriate parties an acknowledgment letter.

If a second level Appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, the member will continue to receive the disputed service/item at the previously authorized level pending resolution of the second level Appeal, if the second level Appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the first level Appeal decision. LaCare also honors a verbal filing of a second level Appeal within ten (10) days of receipt of the written denial decision in order to continue services.

The second level Appeal review is performed by a Second Level Appeal Review Committee, which is comprised of three or more individuals who were not involved in any previous level of review or decision making to deny coverage or payments for the requested service/item. The committee receives a written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question.

The Second Level Appeal Review Committee completes the review within thirty (30) days from receipt of the member's second level Appeal request, which may be extended up to fourteen (14) days at the member's request.

LaCare sends a written notice of the second level Appeal decision to the member and other appropriate parties within five (5) business days of the committee's decision, but not later than thirty (30) days from receipt of the Appeal by LaCare, unless a fourteen (14) day extension was granted. The written notice of the resolution includes the following: The results of the resolution process and the date it was completed.. For appeals not resolved wholly in favor of the members: The right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the LaCare's action.

The member or member representative may file a request for a Fair Hearing within thirty (30) days from the mail date on the written notice of the second level Appeal decision.

Expedited Appeals

An expedited Appeal may be requested if the member or member representative believes that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard Appeal process. An expedited Appeal review may be requested either verbally or in writing.

LaCare must conduct an expedited review of an Appeal at any point prior to the second level Appeal decision. A signed provider certification that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the standard Appeal process must be provided to LaCare per CFR 42 Sec. 438.410 (a) . The provider certification is required regardless of whether the expedited Appeal is filed verbally or in writing by the member or the provider acting on behalf of the member.

Upon receipt of a verbal or written request for expedited review, LaCare verbally informs the member or member representative of the right to present evidence and allegations of fact or of law in person as well as in writing and of the limited time available to do so.

If an expedited Appeal is filed to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving, then the member will continue to receive the disputed service/item at the previously authorized level pending resolution of the expedited Appeal, if the expedited Appeal is hand delivered or post-marked within ten (10) days from the mail date on the written notice of the decision. LaCare also honors a verbal filing of an expedited Appeal within ten (10) days of receipt of the written denial decision in order to continue services.

The expedited Appeal review is performed by the Expedited Appeal Review Committee, which shall include a licensed physician. The committee receives a written report from a licensed physician or other appropriate provider in the same or similar specialty that typically manages or consults on the service/item in question.

The expedited Appeal review process is bound by the same rules and procedures as the second level Appeal review process with the exception of timeframes, which are modified as specified in this section.

LaCare issues the decision resulting from the expedited review in person or by phone to the member and other appropriate parties within seventy–two (72) hours of receiving the member's request for an expedited review. In addition, LaCare mails written notice of the decision to the member and other appropriate parties within two (2) days of the decision. Oral requests for expedited Appeals are committed to writing by LaCare and provided to the member and other appropriate parties via the decision letter.

The member or member representative may file a request for a Fair Hearing within thirty (30) days from the mail date on the written notice of the expedited Appeal decision.

Fair Hearing Procedures

Standard Fair Hearing

Members or member representatives may request a Fair Hearing within thirty (30) days from the mail date on written notice of second level grievance or appeal decision.

Members, or providers filing on behalf of a member, must exhaust LaCare's standard or appeal processes before filing a Fair Hearing Request.

Member can make the request for a Fair Hearing through LaCare who will submit the request and Summary of the case to the Division of Administrative Law or by filing directly with the Division of Administrative Law. The request for a Fair Hearing must include a copy of the written notice of decision that is the subject of the request. Requests must be sent to:

Division of Administrative Law (DAL)
Health and Hospitals Section

Post Office Box 4189
Baton Rouge, LA. 70821-4189
Phone: (225) 342-0443
Fax: (225) 219-9823
Phone for oral appeals: (225) 342-5800

A member who files a request for a Fair Hearing to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the Fair Hearing, if the request for a Fair Hearing is hand delivered or post-marked within ten (10) days from the mail date on the written notice of decision.

Upon receipt of the request for a Fair Hearing, the Divison of Administrative Law (DAL) designee will schedule a hearing. The member and LaCare will receive notification of the hearing date by letter at least ten (10) days in advance, or a shorter time if requested by the member. The letter will outline the type of hearing, the location of the hearing (if applicable), and the date and time of the hearing.

LaCare is a party to the hearing and must be present. LaCare, which may be represented by an attorney, must submit the Summary of Evidence (SOE) and be prepared to explain and defend the issue on appeal. LaCare must submit the SOE packet to the Division of Administrative Law within seven (7) calendar days of receipt of the request for State Fair Hearing if the request is made directly to LaCare.

LaCare will provide the member, at no cost, with records, reports, and documents, relevant to the subject of the Fair Hearing.

The Fair Hearing Decision will be issued within ninety (90) days the the filing and is binding on LaCare If the Division of Administrative Law rules in favor of the claimant/appellant, LaCare will receive a Directive from the Division of Administrative Law. The Directive shall be

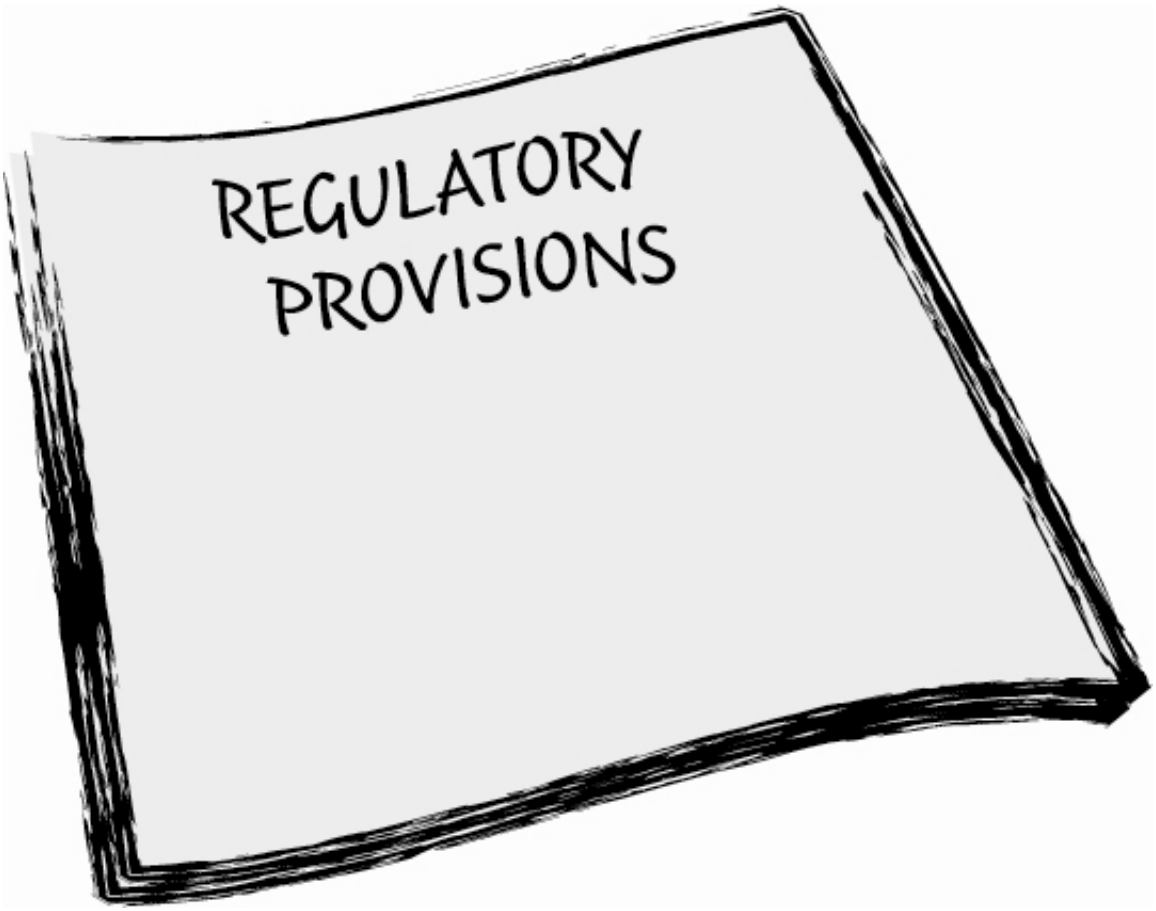
executed within ten days and reported to the DHH within 14 days of the date of the Directive or by the state level appeal's 90th day deadline, whichever is earliest.

PROVISION OF AND PAYMENT FOR SERVICES/ITEMS FOLLOWING DECISION:

If LaCare or the DAL reverses a decision to deny, limit, or delay services/items that were not furnished during the Grievance, Appeal or Fair Hearing process, LaCare will authorize or provide the disputed services/items promptly and as expeditiously as the member's health condition requires.

If LaCare or the DAL reverses a decision to deny authorization of services/items, and the member received the disputed services/items during the Complaint, Appeal or Fair Hearing process, the Plan will pay for those services/items within 10 days or the Fair Hearing decision 90th day timeline, whichever is earliest.

Section XI
Regulatory Provisions



Access to and Financial Responsibility for Services

Member's Financial Responsibilities

If LaCare notifies the Health Care Provider and/or the member that a service will not be covered, and the member chooses to receive that service or treatment, the member can be billed for such services. LaCare members may be directly billed for non-covered services provided they have been informed of their financial responsibility prior to the time services are rendered. The member's informed consent to be billed for services must be documented. It is suggested that the Health Care Provider obtain a signed statement of understanding of financial responsibility from the member **prior to rendering services**.

Services Provided by a Non-Participating Provider

LaCare's Provider Services Department will make every effort to arrange for the member to receive all necessary medical services within LaCare's Network of Providers in collaboration with the recommendations of the PCP. Occasionally, a member's health care needs cannot be met through the LaCare Network of Providers. All services by Non-Participating Providers (except Emergency Services, Family Planning Services, and Medicare covered services by a Medicare Health Care Provider) require Prior Authorization from the LaCare Utilization Management Department. Unauthorized services rendered by Non-Participating Providers are not compensable and may become the financial responsibility of the LaCare member if the member chooses to receive services or treatment by the Non-Participating Provider.

Services Provided Without Required Referral/Authorization

Except for certain services, and network providers for which specific prepayment arrangements have been made, e.g., lab services and certain PCP services, LaCare generally requires referrals and/or Prior Authorization of health care treatment and services rendered to its members. Health care providers should refer to Section II of the Manual titled "Referral and Authorization Requirements" for this information. Members should also be referred to the Member Handbook for a complete listing of those services that require a referral or Prior Authorization. LaCare is not obligated to provide reimbursement for services that have not been appropriately authorized.

Services Not Covered by LaCare

LaCare is a Medicaid Care Organization, and as such, has a benefit structure that closely resembles the Louisiana Medicaid fee-for-service program. LaCare is not responsible for reimbursing for services, treatments, or other items that are outside of the covered benefit structure of LaCare. If LaCare notifies the Health Care Provider and/or the member that a service will not be covered, and the member chooses to receive that service or treatment, the member can be billed by the Health Care Provider for such services provided that the member has been informed of his/her financial responsibility prior to the time services are rendered. Health care providers should refer to Section I of the Manual titled "Benefit Limit and Co-Payment Schedule" or call the LaCare Provider Services Department at **888-922-0007** with questions about covered/non-covered services. members should also be referred to the LaCare Member Handbook or speak with a LaCare Member Services Representative by calling **888-756-0004** when questions arise about services that are or are not covered by LaCare.

Member Accessibility to Providers for Emergency Care

No Prior Authorization for Emergency Services

LaCare does not require Prior Authorization or pre-approval of any Emergency Services.

LaCare PCP and Specialist Office Standards (see Section VI of this Manual) require network providers to provide Medically Necessary covered services to LaCare members, including emergency and/or consultative specialty care services, 24 hours a day, 7 days a week. members may contact their PCP for initial assessment of medical emergencies.

In cases where Emergency Services are needed, members are advised to go to the nearest Hospital Emergency Room (ER), where ER staff should immediately screen all LaCare members and provide appropriate stabilization and/or treatment services.

Care Out of Service Area

LaCare members have access to Emergency Services when traveling anywhere in the United States and its territories, and, with limited exceptions in Canada, Mexico and U.S. territorial Waters. Although not required, members are encouraged to contact their PCP to report any out-of-area Emergency Services received.

Compliance with the HIPAA Privacy Regulations

In addition to maintaining the Corporate Confidentiality Policy, LaCare is required to comply with the Privacy Regulations as specified under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

In order to ensure compliance with these regulations, LaCare takes several measures to ensure such compliance, including, but not limited to, the following:

- Employs a Privacy Officer who is responsible for the directing of on-going activities related to the LaCare's programs and practices addressing the privacy of member's protected health information (PHI)
- Has a centralized Privacy Office, which is responsible for the day-to-day oversight and support of Privacy-related initiatives conducted at LaCare
- Issues copies of LaCare's Notice of Privacy Practices to the recently enrolled and existing membership of the health plan, which describes how medical information is used and disclosed, as well as how it can be accessed
- Established and/or enhanced processes for our members to exercise their rights under these regulations, such as requesting access to their PHI, or complaining about LaCare's privacy practices

Allowed Activities Under the HIPAA Privacy Regulations

The HIPAA Privacy Regulations allow covered entities, including health care providers and health plans (such as LaCare), the ability to use or disclose PHI about its members for the purposes of Treatment, Payment and/or Health plan Operations (TPO) without a member's consent or authorization. This includes access to a member's medical records when necessary and appropriate.

“TPO” allows a Health Care Provider and/or LaCare to share members' PHI without consent or authorization by establishing these purposes as follows:

“Treatment” includes the provision, coordination, management, consultation, and referral of a member between and among health care providers.

Activities that fall within the "**Payment**" category include, but are not limited to:

- Determination of member eligibility
- Reviewing health care services for medical necessity and utilization review
- Review of various activities of health care providers for payment or reimbursement to fulfill LaCare’s coverage responsibilities and provide appropriate benefits
- To obtain or provide reimbursement for health care services delivered to members

“Operations” includes:

- Certain quality improvement activities such as Case Management and care coordination
- Quality of care reviews in response to member or state/federal queries
- Response to member Complaints/Grievances
- Administrative and financial operations such as conducting Health Plan Employer Data And Information Set (HEDIS) reviews
- Member services activities
- Legal activities such as audit programs, including Fraud and abuse detection to assess conformance with compliance programs

While there are other purposes under the Privacy Regulations for which LaCare and/or a Health Care Provider might need to use or disclose a member's PHI, TPO covers a broad range of information sharing.

For more information on HIPAA and/or the Privacy Regulation, please visit the Provider Center at www.lacarelouisiana.com and click on the HIPAA Page or contact the Provider Services Department at **888-922-0007**.

Contact Information

Listed below are general contact addresses for accessing LaCare and other related organizations. For information about additional organizations, contact Provider Services at **888-922-0007**, or Member Services at **888-756-0004**.

LaCare
PO Box 83580
Baton Rouge, LA 70884

Cultural Competency

Cultural Competency is the ability of individuals to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.

Further, Section 601 of Title VI of the Civil Rights Act of 1964 states that:

No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Members must be provided all covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated.

Discriminatory actions against those of Limited English Proficiency (LEP), Low Literacy Proficiency (LLP) or sensory impairment can be seen as discrimination on the basis of national origin. Therefore, these Medicaid recipients must be allotted equal access to all services and benefits of LaCare.

Recipients of federal financial assistance would include the Medicaid Program, and by extension, Medicaid Managed Care Organizations, i.e., LaCare and its network providers.

Title III of the Americans with Disabilities Act (ADA) states that public accommodations must comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. Public accommodations (such as health care providers) must specifically comply with, among other things, requirements related to effective communication with people with hearing, vision, or speech disabilities, and other physical access requirements.

Communication, whether in written, verbal, or "other sensory" modalities is the first step in the establishment of the patient/ Health Care Provider relationship. The key to ensuring equal access to benefits and services for Limited English Proficiency (LEP), Low Literacy Proficiency (LLP) and sensory impaired members is to ensure that our network providers can effectively communicate with these members. LaCare network providers are obligated to offer translation services to LEP and LLP members, and to make reasonable efforts to accommodate members with other sensory impairments.

If a LaCare member requires or requests translation services because he/she is either non-English speaking, or of limited or low English proficiency, or if the member has some other sensory impairment, the Health Care Provider has a responsibility to make arrangements to procure translation services for those members, and to facilitate the provision of health care services to such members.

In order to be in compliance with federal law and state contractual requirements, LaCare and its network providers have an obligation to provide interpreter services to LEP and LLP members and to make reasonable efforts to accommodate members with other sensory impairments.

Health care providers who are unable to arrange for translation services for an LEP, LLP or sensory impaired member should contact LaCare's Member Services **888-756-0004**, and a representative will assist in locating a professional interpreter that communicates in the member's primary language.

LaCare's Corporate Confidentiality Policy

The policy states that during the course of business operations, Confidential Information and/or Proprietary Information, including member Protected Health Information (PHI), may become available to LaCare Associates, Consultants and Contractors. LaCare's use and disclosure of

member PHI is regulated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations. LaCare's use and disclosure of PHI is also impacted by applicable state laws and regulations governing the confidentiality and disclosure of health information.

LaCare is committed to safeguarding Confidential Information and Proprietary Information, including ensuring the privacy and security of member PHI, in compliance with all applicable laws and regulations. It is the obligation of all LaCare Associates, Consultants and Contractors to safeguard and maintain the confidentiality of Confidential and Proprietary Information, including PHI, in accordance with the requirements of all applicable federal and state statutes and regulations as well as the provisions of LaCare's Confidentiality Policy and other LaCare policies and procedures addressing Confidential and Proprietary Information, including PHI.

All Confidential Information and Proprietary Information, including PHI, will be handled on a need-to-know basis. The LaCare Confidentiality Policy and other LaCare policies and procedures are adopted to protect the confidentiality of such information consistent with the need to effectively conduct business operations without using or disclosing more information than is necessary, for example, conducting research or measuring quality through the use of aggregated data wherever possible. No Associate, Consultant or Contractor is permitted to disclose Confidential Information or Proprietary Information pertaining to LaCare or a member to any other Associate, Consultant or Contractor unless such a disclosure is consistent with the LaCare Confidentiality Policy.

Both during and after an Associate's association with the LaCare, it shall be a violation of the LaCare Confidentiality Policy to discuss, release, or otherwise disclose any Confidential Information or Proprietary Information, except as required by the Associate's employment relationship with LaCare or as otherwise required by law. It is also a violation of LaCare's Confidentiality Policy for any Associate to use Confidential Information or Proprietary Information for his/her own personal benefit or in any way inconsistent with applicable law or the interests of LaCare. To the extent that a violation of the LaCare Confidentiality Policy occurs, LaCare reserves the right to pursue any recourse or remedy to which it is entitled under law. Furthermore, any violation of the LaCare Confidentiality Policy will subject the Associate(s) in question to disciplinary action, up to and including termination of employment.

The following information is provided to outline the rules regarding the handling of confidential information and proprietary information within LaCare.

Confidential information and proprietary information includes, but is not limited to the following:

- Protected Health Information
- Medical or personal information pertaining to Associates of LaCare ("the Company") and/or its Customers
- Accounting, billing or payroll information, and data reports and statistics regarding the Company, its Associates, members, and/or Customers
- Information that LaCare is required by law, regulation, agreement or policy to maintain as confidential
- Financial information regarding the Company, its members, network providers and Customers, including but not limited to contract rates and fees
- Associate personnel and payroll records

- Information, ideas, or data developed or obtained by LaCare, such as marketing and sales information, marketplace assessments, data on customers or prospects, proposed rates, rating formulas, reimbursement formulas, Health Care Provider payment rates, business of LaCare and/or its Customers
- Information not generally known to the public upon which the goodwill, welfare and competitive ability of LaCare and/or its Customers depend, information regarding product plans and design, marketing sales and plans, computer hardware, software, computer systems and programs, processing techniques, and general outputs
- Information concerning LaCare 's business plans
- Information that could help others commit Fraud or sabotage or misuse LaCare 's products or services

Procedure

1. Associates, Consultants and Contractors may use Confidential or Proprietary Information and may disclose Confidential or Proprietary Information internally within LaCare only as necessary to fulfill the responsibilities of their respective position.
2. Confidential Information which is specific to an Associate or Health Care Provider may not be released by LaCare to another party, except as permitted or required by law or regulation, without first obtaining the written consent of that individual. PHI may not be disclosed, other than as permitted or required by law or regulation, or for purposes of treatment, payment or health care operations, without first obtaining a written Authorization as required by HIPAA, or other form of consent as may be required by state law. If an individual is unable to make his/her own decision regarding consent, a legal guardian or other legally authorized representative must provide written consent or an Authorization on the individual's behalf.
3. Associates, Consultants or Contractors, may not disclose Confidential or Proprietary Information to persons or organizations outside LaCare, unless otherwise required by law or regulation or approved by the Legal Affairs Department. Associates, Consultants or Contractors may not make any direct or indirect communication of any kind with the press or any other media about the business of LaCare without express written approval from the Communications Department.
4. Information that pertains to LaCare 's operations may be disclosed to LaCare’s general partners, Mercy Health Systems and/or VISTA Health Plan, Inc. d/b/a Keystone First, on a need to know basis; provided, however, that Confidential Information and Proprietary Information belonging or pertaining to a Customer may be disclosed ONLY to representatives of that Customer.
5. Any Associate, Consultant or Contractor who is approached with an offer of Confidential Information including PHI or Proprietary Information to which he/she should not have access and/or which was improperly obtained must immediately discuss the matter with his/her supervisor, an attorney in the Legal Affairs Department, the Chief Compliance Officer or the Internal Auditor.

6. All Associates, Consultants and Contractors must review and familiarize themselves with all departmental or any other LaCare policies and procedures applicable to confidentiality issues arising within the course of performing their job duties.
7. Each Associate's, Consultant's, and Contractor's level of access to the information maintained in LaCare 's computer system is determined by the Information Services Department, based upon the individual's department and job duties. Associates are to access and distribute data electronically only in accordance with instructions given by the Information Services or the Corporate Compliance departments. All Associates, Consultants and Contractors are required to comply with the Information Services policies and procedures regarding security and access to data, electronic mail and other information systems.
8. Associates, Consultants and Contractors must also follow reasonable confidentiality restrictions imposed by previous employers and not use or share that employer's confidential information with LaCare.
9. All Consultants/Contractors, including those who are members of LaCare committees, will sign a confidentiality and non-disclosure agreement for the protection of Confidential Information and Proprietary Information.
10. All agreements with network providers, Consultants and Contractors will include confidentiality provisions that are consistent with this Policy and Procedure and that require, at a minimum, that the Provider/Subcontractor comply with all federal and state statutes and regulations regarding the disclosure of Confidential Information and otherwise maintain LaCare's Confidential Information and Proprietary Information as confidential. The material elements of this policy and procedure will be communicated to participating network providers via LaCare 's network provider agreements and network provider manuals. To the extent that a Health Care Provider, Consultant or Contractor is a Business Associate pursuant to HIPAA, such Health Care Provider, Consultant or Contractor must execute a Business Associate agreement governing the Business Associate's use and disclosure of Protected Health Information as required by HIPAA.
11. The Legal Affairs and/or Corporate Compliance Department should be contacted whenever issues of confidentiality and/or disclosure of Confidential Information or Proprietary Information arise which are not clearly addressed in the LaCare Confidentiality Policy or other LaCare policies and procedures.
12. The Chief Compliance Officer will report to the Compliance and Privacy Committee, all member, Health Care Provider and Associate complaints regarding confidentiality as well as the resolution of such complaints. The Compliance and Privacy Committee will determine if operational practices should be altered to prevent or reduce the risk of future concerns.

Provider Protections

LaCare shall not exclude, discriminate against or penalize any Health Care Provider for its refusal to allow, perform, participate in or refer for health care services, when the refusal of the

Health Care Provider is based on moral or religious grounds. The Health Care Provider must make information available to members, prospective members and LaCare about any such restrictions or limitations to the types of services they will/will not make referrals for or directly provide to LaCare members, due to religious or moral grounds.

Health care providers are further protected in that no public institution, public official or public agency may take disciplinary action against, deny licensure or certification or penalize any person, association or corporation attempting to establish a plan, or operating, expanding or improving an existing plan, because the person, association or corporation refuses to provide any particular form of health care services or other services or supplies covered by other health plans, when the refusal is based on moral or religious grounds. LaCare will not engage in or condone any such discriminatory practices.

LaCare shall not discriminate against or exclude from LaCare's Provider Network any Health Care Provider because the Health Care Provider advocated on behalf of a member in a Utilization Management appeal or another dispute with LaCare over appropriate medical care, or because the Health Care Provider filed an appeal on behalf of a LaCare member.

LaCare does not have policies that restrict or prohibit open discussion between health care providers and LaCare members regarding treatment options and alternatives. LaCare encourages open communication between health care providers and our members with regard to all treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

Additional Resources

Network providers should always have the most current regulatory requirements. Please call **888-922-0007** or call your Network Development Representative for additional information. You should consult an official publication or reporting service if you want to be assured you have the most up-to-date version of these regulations.

Below are some helpful links to federal and state regulations and state bulletins and other relevant general information. Announcements and new bulletins will also be posted on at www.lacarelouisiana.com.

CMS

www.cms.gov

Code of Federal Regulations

http://www.gpoaccess.gov/cfr/index.html

Lousiana Laws

Louisana Laws can be researched through the Louisiana State Legislature website

http://www.legis.state.la.us/

Click on Louisiana Laws along the left hand banner – then click table of contents. Once at the Table of Contents click on Revised Statutes. It will bring you to a listing of all Louisiana Statutes.

Louisiana Office of State Register

The *Louisiana Register* is a monthly publication which provides an access to the certified regulations and legal notices issued by the executive branch of the state government. All of these go through the formal rulemaking process. Proposed and final rules published in the Louisiana Register are codified for easy Louisiana Administrative Code research capabilities

http://doa.louisiana.gov/osr/reg/register.htm

Medicaid websites

www.lamedicaid.com

Louisiana Department of Health and Hospitals

http://new.dhh.louisiana.gov/index.cfm/page/277

Louisiana helpful resources for your patients

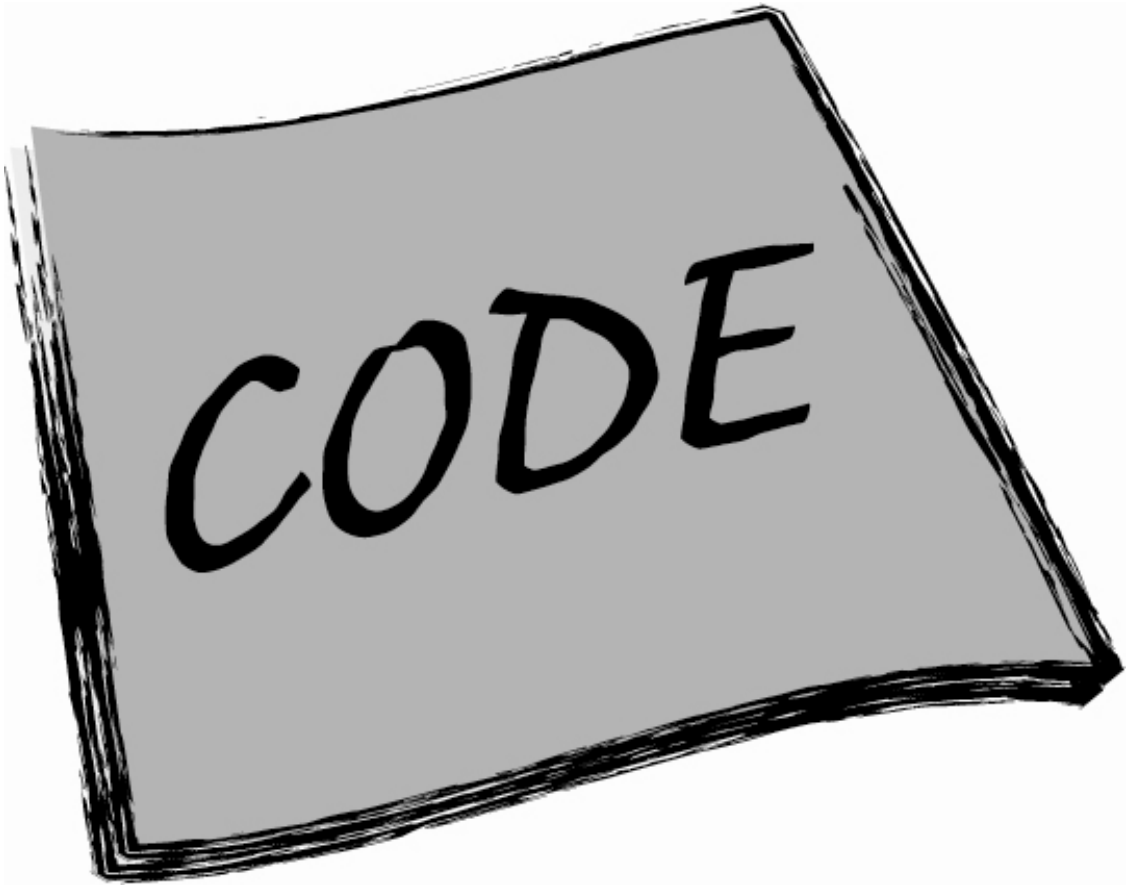
A listing of additional services available in the community to your members. This includes contact information for WIC, advocacy, legal services, other human services, emergency, Department of Education and more and was compiled by DHH's Louisiana Children's Special Health Services (CSHS) and is localized to specific regions.

http://www.dhh.louisiana.gov/publications.asp?ID=256&Detail=3089

We have included copies below but most current versions can be found online. We will include other resources on a regular basis.

Section XII

ACCESSING OTHER MEDICAID COVERED SERVICES AND COMMUNITY RESOURCES NOT COVERED BY LaCare



LaCare covers all benefits included in the Community Care Network Program by the Department of Health and Hospitals. There are additional Medicaid benefits available to eligible Medicaid recipients that continue to be covered by DHH through existing processes. Please see below.

DENTAL

To locate a Medicaid dentist call 1-877-455-9955 or use the Medicaid provider search page.

Medicaid - Age 0–21

The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the child health component of Medicaid.

- Covered services- bi-annual dental screening, examination, X-rays, cleaning, topical fluoride application, hygiene education.
- Early & Periodic Screenings, Diagnosis, Treatment (EPSDT) Dental Program covers certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply. Some EPSDT services may need Prior Authorization from Medicaid.
- Patients are to see Medicaid accepting dentists. To locate a Medicaid dentist call 1-877-455-9955 or use the Medicaid provider search page.
- Dental services may also be obtained from:
    - Federally Qualifying Health Center (FQHC)
    - LSU School of Dentistry New Orleans Clinic (not free)
    - LSU School of Dentistry Satellite Dental Clinics (not free)

Pregnant with No Dental Insurance

LaMOMs – Age less than 21

- The LaMOMS program is an expansion of Medicaid coverage for pregnant women.
- Dental services end at the birth of the baby, regardless of LaMOMs enrollment status, miscarriage, or pre-term delivery
- Medicaid covered services include dental screening, examination, X-rays, cleaning, topical fluoride application, hygiene education.
- Early & Periodic Screenings, Diagnosis, Treatment (EPSDT) Dental Program covers certain other dental services (some may need prior authorization).
- Patients are to see Medicaid accepting dentists. To locate a Medicaid dentist call 1-877-455-9955 or use the Medicaid provider search page.
- Dental services may also be obtained from:
    - Federally Qualifying Health Center (FQHC)
    - LSU School of Dentistry Satellite Dental Clinics (not free)

Expanded Dental Service for Pregnant Women (EDSPW) - Age 21 – 59

- Expanded Dental Services for Pregnant Women (EDSPW- Medicaid) allows pregnant women to receive dental services while they are pregnant. Dental services end when the pregnancy ends, regardless of when the birth occurs or if there is a miscarriage.
- Patients must obtain a referral from the medical professional providing pregnancy care using the BHSF Form 9-M. The recipient must provide the original completed form to a participating dentist or have the referring medical professional fax or scan the form to the dentist before receiving any dental services covered by Medicaid.
- Medicaid covered services include dental screening, examination, X-rays, cleaning, topical fluoride application, hygiene education.
- Patients are to see Medicaid accepting dentists. To locate a Medicaid dentist call 1-877-455-9955 or use the Medicaid provider search page.
- Dental services may also be obtained from:
    - Federally Qualifying Health Center (FQHC)
    - LSU School of Dentistry Satellite Dental Clinics (not free)

Adult Denture Program

- Medicaid recipients 21 years of age and older. Dentures, denture relines, and denture repairs are covered under this program, as well as examination and x-rays in conjunction with the construction of a Medicaid-authorized denture.
- Patients are to see Medicaid accepting dentists. To locate a Medicaid dentist call 1-877-455-9955 or use the Medicaid provider search page.

Early Steps (Early Intervention System)

Louisiana's Early Intervention is a collection of services and supports that help families to enhance their skills in raising a child with disabilities and are covered through the. Louisiana's Early Steps Program. LaCare will help coordinate services and access to early intervention programs.

Early Steps provides services to families with infants and toddlers aged birth to three years (36 months) who have a medical condition likely to result in a developmental delay, or who have developmental delays. Children with delays in cognitive, motor, vision, hearing, communication, social-emotional or adaptive development may be eligible for services. Early Steps services are designed to improve the family's capacity to enhance their child's development. These services are provided in the child's natural environment, such as the child's home, child care or any other community setting typical for children aged birth to 3 years (36 months).

When a child turns three years of age, the responsibility for funding Early Intervention services is an education expense. Children may remain eligible for Early Intervention services through the minimum age at which a child can attend first grade in his/her own school district.

An infant or toddler (birth to three years of age) is eligible for Early Intervention Services if he/she:

- Shows a significant delay in one or more areas of child development
- Has a physical disability, a hearing or vision loss
- Receives a specialist's determination that a delay exists even though it is not evident on evaluations (called informed clinical opinion)

- Has a known physical or mental condition with a high probability for developmental delay (Down Syndrome is one example)

If an infant or toddler is found not to be eligible for Early Intervention, he/she may still be eligible for follow-up tracking in the event the needs of the child and family change.

Children eligible for tracking are:

- Born weighing less than 3 ½ pounds
- Cared for in a neonatal intensive care unit
- Born to mothers who are chemically addicted
- Found to have blood lead levels at 15 micrograms per deciliter and above

The services provided to eligible children and their families are individualized in accordance with the developmental needs of each child. Early Intervention supports may include a range of informal and formal opportunities, experiences and resources found in each family's community. Services may be provided in the child's home, childcare center, nursery school, playgroup, or other community settings where the child would be found if he or she did not have a disability.

Families with concerns about their child's development should consult their family network provider. If parents have continuing concerns, or want additional information, please go to the Early Steps website: http://new.dhh.louisiana.gov/index.cfm/page/139/n/139.

Referrals to Early Intervention are directed to the System Point of Entry Office in the region of Louisiana where the family resides. Initial contact with the referred family occurs locally at a time and place convenient to the family. A screening at no-cost to the family will be offered to determine if the child shows any areas of delay. Further evaluations may determine eligibility for Early Intervention services or follow-up tracking

PHARMACY

Louisiana Medicaid Pharmacy Benefits Management Program is the first state-owned and administered Pharmacy Benefit Management (PBM) system for Medicaid in the nation. Prescription services are one of the largest service and expenditure areas under the Medicaid program, and this program coordinates all Medicaid pharmacy-related services.

Contact the Medicaid Pharmacy Benefits Management Program at 1.800.437.9101

Pharmacy Benefit is <u>not</u> administered by LaCare, AmeriHealth Mercy of Louisiana

The below information is provided as a reference for LaCare Associates assisting Providers and Members with requests and/or issues related to the State administered pharmacy program.

Preferred Drug Listing and Prior Authorization Process

The Medicaid program administers a prior authorization process for services in its Pharmacy Benefits Management System. The Prescription Prior Authorization (RxPA) operations are operated by the **University of Louisiana at Monroe College of Pharmacy - Office of Outcomes Research and Evaluation.**

The RxPA process uses a Preferred Drug List (PDL) for selected therapeutic classes. Drugs included on the PDL are automatically prior authorized. Drugs in these classes that are not included on the PDL require prescribers to obtain prior authorization.

Providers are notified of the drugs selected for placement on the Preferred Drug List by therapeutic classes prior to implementation of the prior authorization process and as additional drugs are added to the list. Lists of covered drug products, including those that require prior authorization, can be viewed at the following link:
http://www.lamedicaid.com/provweb1/pharmacy/preferred_list.htm

Requests for Prior Authorization

8am – 6pm CT; Monday - Saturday

Phone: 1-866-730-4357

Fax: 1-866-797-2329

Mail:

ULM – College of Pharmacy
Rx PA Program
1401 Royal Avenue
Monroe, LA 71201

Molina Medicaid Solutions Provider Relations Unit

Phone: 225-924-5040 or 800-473-2783

Pharmacy can submit paper claims to

Molina
P. O. Box 91020
Baton Rouge, LA 70821

Care Coordination: Managing Member Inquiries Concerning Pharmacy Benefit - (Quick Reference)

Co-Payments

Co-payment will be paid by the Medicaid recipient and collected by the provider/pharmacy at the time the service is rendered. Medicaid reimbursement to the provider/pharmacy shall be adjusted to reflect the co-payment amount for which the recipient is liable.

In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the co-payment amount. The recipient's assertion of his/her inability to pay the co-payment establishes the inability. *Under 42 CFR 447.15, this service statement does not apply to any individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the co-payment.*

Cost	Medicaid Recipient co-payment amount
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The following pharmacy services are exempt from the co-payment requirement:

- Services furnished to individuals under twenty-one years of age
- Services furnished to pregnant women if such services are related to the pregnancy, or any other medical conditions that complicate the pregnancy
- Services furnished to any individual who is an inpatient in a hospital, long term care facility, or other medical institution. Individuals in group homes are classified in this category
- Emergency services provided in a hospital, clinic, physician's office, or other facility equipped to furnish emergency care
- Family planning services and supplies. (Prescriptions for family planning services may be prescribed by any prescribing practitioner). These drugs and supplies include contraceptives, spermicides, and condoms, and require a prescription
- Services furnished to individuals determined to be American Indians
- Influenza Vaccine Administration by Pharmacists

Louisiana Medicaid will reimburse enrolled pharmacies when Influenza Vaccine (immunization) is administered by a pharmacist who has the authority to administer authorized by the Louisiana Board of Pharmacy.

Effective January 1, 2011, Louisiana Medicaid reimburses enrolled pharmacies for the cost of the influenza vaccine as well as the administration of the vaccine (intramuscular or intranasal) for Medicaid recipients who are nineteen years of age and older when the administering pharmacist is an enrolled Medicaid provider.

- No reimbursement of the vaccine or supplies will be made for children under the age of nineteen years of age. Only the administration fee (intramuscular or intranasal) will be reimbursed for these recipients. Vaccines are provided by the Louisiana Vaccines for Children (VFC) Program. Once administered, pharmacists shall document these immunizations in the Louisiana Immunization Network for Kids Statewide (LINKS) registry found at www.dhh.la.gov

Coverage for OTC drugs, items and supplies

Only a limited number of non-legend or over-the-counter (OTC) drugs, items and supplies can be reimbursed by the Louisiana Medicaid program. For Medicaid reimbursement, they must be prescribed by licensed practitioners. The drug manufacturer must participate in the federal rebate program.

The following are covered by Louisiana Medicaid when an authorized prescriber has written a prescription:

- Insulin
- Sodium chloride solution for inhalation therapy
- Contraceptives, topical

- Urinary pH modifiers
- OTC Vitamin D preparations
- OTC Vitamin E preparations
- OTC Niacin preparations
- OTC Calcium replacement agents
- OTC Magnesium replacement agents
- OTC Phosphate replacement agents
- OTC Iron replacement agents
- Normal saline and heparin flushes
- Disposable needles and syringes used to administer insulin
- Test strips for determining blood glucose levels
- Lancets
- Urine test strips (e.g., Clinitest® and Clinistix®)
- Family planning items
- Other non-legend drugs, items and supplies that have Medicaid Pharmacy program approval.

Diabetic Testing Supplies

The Medicaid Pharmacy Program reimburses claims for prescribed diabetic testing supplies.

Smoking Cessation:

Nicotine Transdermal Nicotine transdermal patches, nicotine polacrilix gum, and nicotine spray are Patches,Gum and Spray

Nicotine transdermal patches, nicotine polacrilix gum, and nicotine spray are covered only with a handwritten prescription signed by the prescribing practitioner. There are no provisions for refills. The physician will need to rewrite a prescription each time.

Also, physicians must certify, in their own handwriting, either directly on the prescription or on an attachment to the prescription that the recipient is enrolled in a physician-supervised behavioral program in order for Medicaid to provide coverage for nicotine adhesive patches, gum and spray.

Pharmacy providers should verify that the above noted documentation is written on or attached to the prescription when the prescription is dispensed. This information must be retained by the pharmacy as evidence of compliance with program policy, and it must be readily retrievable when requested by audit staff.

Lost or Stolen Medications

There is no provision for lost or stolen medications. If appropriate, encourage member to file a police report. See Emergency Supplies, if needed - below.

Early Refill

The Medicaid program denies pharmacy claims for early refills if the patient has requested the same medication at the same pharmacy prior to seventy-five percent of medication being utilized. This translates into a seven (7) day window based on a thirty (30) day supply.

Prescriptions for narcotic analgesics will deny for an early refill edit when less than eighty-five percent of the medication had been utilized. This translates into a three (3) day window based on a thirty (30) day supply.

Emergency Supplies (for medications requiring prior authorization)

Prescriptions indicating emergency situations shall be dispensed in a MINIMUM quantity of a 3-day supply. Refills for the dispensing of the non-preferred products in these emergency situations are not permitted. The recipient's practitioner must contact the Prior Authorization Unit [1-866-730-4357; Monday – Saturday 8am to 6pm Central Time Zone] to request authorization to continue the medication past the emergency supply, and a new prescription must be issued.

Emergency process may be used when the Prior Authorization Unit is closed (non-working hours, holidays and Sunday) or when the PA system is unavailable. The pharmacist may also use professional judgment in situations that would necessitate an emergency supply.

Special note to Practitioner/Pharmacy: prescribing practitioner must indicate that the prescription is an emergency Rx on the face of the prescription, if in hard copy, or if the prescription is called in to the pharmacy, the emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency Rx" on the hard copy prescription. When the pharmacist determines the prescription is an emergency, the pharmacist must indicate "Emergency by Pharmacist" on the hard copy prescription. The pharmacist must code the claim as an emergency prescription (enter "03" in the NCPDP Field #487). An NCPDN educational alert will notify the pharmacist that the drug requires prior authorization.

Out-of-State Pharmacy Coverage

Medicaid does not reimburse for services provided to recipients when they are out of the United States

- Louisiana Medicaid will reimburse out-of-state services only under the following circumstances:
- Where an emergency arises from an accident or illness
- Where the health of the individual would be endangered if he/she undertook travel to return to the State of Louisiana
- Where the health of the individual would be endangered if the care and services are postponed until he/she returns to the state
- When it is general practice for residents of a particular locality to use medical resources in the medical marketing areas outside of the state
- When the medical care and services or needed supplementary resources are not available within the state. Prior approval for these services is required.

These are the only circumstances in which an out-of-state pharmacy may be reimbursed for providing pharmacy services to Louisiana Medicaid recipients. The out-of-state pharmacy must obtain a provider enrollment number to secure reimbursement.

Nutrition Therapy

The Pharmacy program covers the following services, equipment and supplies when medical necessity and other program criteria are met:

- Parenteral Nutrition Therapy/Total Parenteral Nutrition Therapy (TPN) is covered for a patient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient‘s general condition
- Intradialytic Parenteral Nutrition Therapy (IDPN) provided to an end stage renal disease (ESRD) patient while the patient is being dialyzed
- Equipment and Supplies-Infusion pumps and accessories

Lock-In Program

Recipients placed in Lock-In have been identified as using medications inappropriately and in many cases using multiple prescribers and pharmacies. Restricting them to a prescriber and a pharmacy enables the practitioners to better manage their care.

A Medicaid recipient loses his/her freedom of choice of providers when selected for enrollment in the Lock-In program. A Lock-In recipient is asked to choose one primary care physician provider, specialist when warranted, and one pharmacy provider to be the Lock-In providers. Only physicians can prescribe medications for Lock-In recipients. Approval of selections is required from the Louisiana Medicaid Pharmacy Program.

Under most circumstances, recipients with providers listed under the Lock-In segment of REVS or MEVS are restricted to receiving physician and pharmacy services from these providers.

The Lock-In system affects the recipients only in the areas of physician and pharmacy services. Services other than physician or prescription drug services may be rendered to eligible recipients without Lock-In restrictions.

For emergencies - “Emergency Prescription” or “Discharge Prescription” should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist. Please ensure that the notation is included on the hard copy claim for audit purposes.

If a recipient chooses to change Lock-In provider(s) or add a specialist, the recipient must contact their local Medicaid office. If a provider chooses to no longer be a recipient‘s Lock-In provider, the provider should contact the Lock-In Unit at 225-216-6245 or Fax 225-216-6334.

Source: Louisiana Medicaid Program Provider Manual, Chapter 37, Pharmacy Benefits Management Services: revised date 4/01/2011

TOBACCO CESSATION

The Louisiana Tobacco Control Program is funded through a cooperative agreement from the Centers for Disease Control Office on Smoking and Health (CDC-OSH). The program began receiving funding from the Centers for Disease Control and Prevention in 1993. This program is within the Louisiana Department of Health and Hospitals' Office of Public Health – under the direction of the Bureau of Primary Care and Rural Health’s Chronic Disease Prevention and Control Unit.

Smoking Cessation Services are <u>not</u> administeredby LaCare, AmeriHealth Mercy of Louisiana

The below information is provided as a reference for LaCare Associates assisting Providers and Members with requests and/or issues related to the State administered smoking cessation programs and pharmacy benefit.

Toll-free Tobacco Smoking Cessation Helpline

The OPH Tobacco Control Program supports a toll-free cessation helpline, 1-800-LUNG USA, **[1-800-586-4872]** through a contract with the American Lung Association of Louisiana and a contract with an advertising agency. When the public calls the helpline, they can get tobacco cessation information mailed to them, or they can receive counseling from professional cessation experts.

The Louisiana Tobacco Quitline (QL)

1-800-QUIT-NOW, **[1-800-784-8669]** provides free confidential advice and support by a trained tobacco cessation specialist to Louisiana residents ages 13 and older who want to quit using tobacco. Service is available in various languages such English and Spanish. TYY and TDD accommodations for hearing impaired and deaf individuals are available at 1-800-228-4327.

Freedom From Smoking® Online, an Internet-based program available 24/7 www.ffsonline.org

Other online resources are available at http://www.quitwithusla.org/

Louisiana Tobacco Control Program Tobacco Smoking Cessation Support Services Medicaid Recipients/Support Groups

TOBACCO CONTROL INITIATIVE (TCI)

The Tobacco Control Initiative provides multi-level tobacco cessation services in 10 Louisiana Hospitals that combine behavioral counseling, social support and pharmacotherapy to help patients kick their tobacco habit.

Listing of area hospitals participating in this program along with contact information for each

Region	Location:	Contact information
1	**New Orleans** Medical Center of Louisiana at New Orleans	(504) 280-1550
2	**Baton Rouge** Earl K. Long Medical Center	(225) 358-2184
3	**Houma** Leonard J. Chabert Medical Center	(985) 873-2499
4	**Lafayette** University Medical Center	(337) 261-8541
5	**Lake Charles** Walter O. Moss Regional Medical Center	(337) 475-8308

Region	Location:	Contact information
6	**Pineville** Huey P. Long Medical Center	(318) 483-7121
7	**Shreveport** LSU Health Sciences Center	(318) 813-2233
8	**Monroe** E. A. Conway Medical Center	(318) 330-7757
9	**Independence** Lallie Kemp Medical Center	(985) 878-1362

Louisiana Tobacco Control Program Tobacco Smoking Cessation Support Services - Medicaid Recipients/Support Groups

FREEDOM FROM SMOKING CLINICS Led by American Lung Association-certified facilitators, the **eight-session, five-week group program** is perfect for people looking to join a support group. The program teaches participants to track personal habits and develop coping strategies - all in a supportive environment with others who are experiencing the same feelings and facing the same challenges.

Topics include: recovery symptoms, weight control, stress management/relaxation techniques and how to calm the urge to smoke. Participants also learn techniques for cognitive control and relaxation and receive information about how to use helpful tools, diets and support systems to quit successfully.

Call 1-800-LUNG-USA for updates to the below listing

Region	Location:	Contact information
1	**New Orleans Area:** American Lung Association of LA, Inc. Office Headquarters: 2325 Severn Avenue, Suite 8, Metairie, LA 70001	**504-828-5864**
2	Baton Rouge General Medical Center 8585 Picardy Avenue, Baton Rouge, LA 70809	**225-763-4472**
2	Ochsner Medical Center of B. R. 17000 Medical Center Drive, Baton Rouge, LA 70816	**255-755-4811**
2	West Feliciana Parish Hospital 5226 Commerce Street, St. Francisville, LA 70775	**225-635-3811**
3	Assumption Community Hospital 235 Highway 402, Napoleonville, LA 70390	**985-369-3600**
3	Terrebonne General Medical Center TGMC Outreach Center, Southland Mall 5953 West Park Avenue, Ste.3003, Houma, LA 70364	**985-876-7577**
4	Southwest Area Health	**337-989-0001**

Region	Location:	Contact information
	Education Center (S.W.L.A.H.E.C.) 103 Independence Boulevard, Lafayette, LA 70506	
5	Southwest Area Health Education Center (S.W.L.A.H.E.C.) 715 Ryan Street, Suite 104, Lake Charles, LA 70601-4200	**Phone: 337-989-0001**
6	There are no listings for this Region	
7	Christus Schumpert Medical Center One Saint Mary Place, Shreveport, LA 71101	**318-681-6645**
7	Natchitoches Parish Hospital 501 Keyser Avenue, Natchitoches, LA 71457	**318-214-4344**
7	Willis-Knighton Health System 2600 Greenwood Road, Shreveport, LA 71103	**318-212-4450**
8,9	**There are no listings for these Regions**	

Louisiana Tobacco Control Program Tobacco Smoking Cessation Support Services - Providers and Clinicians

Fax-to-Quit - Louisiana uses the Louisiana Tobacco Quitline to help clinicians provide the counseling component easily and seamlessly. The offering is intended as a Treatment program for patients who have expressed an interest in quitting smoking within the next 30 days. **The Quitline is not designed to convince patients to quit smoking.** To access program information and the training module, visit http://www.quitwithusla.org/healthcareproviders/faxtoquit/

To become a certified Fax-To-Quit provider, providers must complete a training module. The presentation takes about 15 minutes and will be followed by a short quiz. For participating in the program, offices will also receive a Certified Health Care Provider Tool Kit featuring:

- Fax-To-Quit Manual
- Office Guide
- Medicaid Brochure
- Quit Referral Cards
- Consent Form (must be signed by patient)

The Quitline does not provide medication **[see below] -** but will provide the counseling component of an intervention. It is up to the clinician to prescribe or recommend the medication. After the patient gives informed consent, the signed form is faxed to the Quitline. A Quitline Intake Specialist will contact the tobacco user, within 2-3 days to provide an intervention upon receiving the completed consent form from the clinic.

Medications:

Nicotine transdermal patches, nicotine polacrilix gum, and nicotine spray are covered only with a handwritten prescription signed by the prescribing practitioner. There are no provisions for refills. The physician will need to rewrite a prescription each time.

Also, physicians must certify, in their own handwriting, either directly on the prescription or on an attachment to the prescription that the recipient is enrolled in a physician-supervised

behavioral program in order for Medicaid to provide coverage for nicotine adhesive patches, gum and spray.

Maternity Smoking Cessation:

The Louisiana SBIRT-Healthy Babies Initiative is a partnership with the Office of Addictive Disorders and the Office of Public Health within the Louisiana Department of Health and Hospitals, the American College of Obstetricians and Gynecologists (ACOG), March of Dimes, Fetal Infant Mortality Review and The Louisiana Campaign for Tobacco-Free Living. The initiative begins with teaching physicians and other healthcare professionals to counsel pregnant women using the "4 Ps Plus Screening Tool" during regularly scheduled appointments. It is simple, brief and proven to work. For more information or to set up a time for office training, please contact:

Mary Craig, RN, MSN, MS, Office of Public Health - Maternal and Child Health - 504-219-4572 or mcraig@dhh.la.gov

WIC BASICS

The Women, Infants and Children Program (WIC) is a supplemental nutrition program established by the USDA to serve eligible pregnant, breastfeeding, and postpartum women, infants and children less than 5 years of age. It is intended to encourage patients to access preventive health care and to provide supplemental food and nutrition education to those at nutrition risk.

Pregnant and postpartum women, infants, and children (under 5 years old) may qualify to participate in the WIC program. Those whose income meets the WIC income guidelines or who participate in the Medicaid, FITAP, or Supplemental Food Assistance Program-SNAP (formerly Food Stamp Program), and who are also at nutrition risk, as defined by WIC regulations, are eligible for WIC benefits.

The WIC program needs certain medical information supplied by a physician in order to process the application. Please see the WIC – 17 form located in **Appendix 5** in this manual, or refer to **The Physician's Guide to the Louisiana WIC Program** for complete information about the program, located in the Provider Center at www.lacarelouisiana.com. This form should be completed by the physician and given to the LaCare member to bring to the WIC appointment.

The WIC program offers the following services:

- Nutrition screening and assessment
- Nutrition counseling
- Nutritious food package
- Breast-feeding guidance
- Breast pump loan program
- Food Tastings
- Nutrition activities and group classes
- Infant formula preparation education
- Cooking demonstrations and recipes
- Referral assistance to other public programs

LaCare members who wish to apply for WIC may call **1-800-251-BABY** to locate WIC clinics in their area. The Louisiana Department of Health and Hospitals, Office of Public Health web site at http://www.wic.dhh.louisiana.gov also has a list of WIC clinics.

COMMUNITY/HUMAN SERVICES RESOURCES

The following are guides to local resources prepared by the Louisiana DHH/Children's Special Health Services (CSHS) 6/2011 and are also online at http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=28

These are important sources of additional help and other service information for your patients that can contribute to their overall wellness.

RESOURCES for MEDICAL HOME - CARE COORDINATION Region 1

(The parishes of: Jefferson; Orleans; Plaquemines; St. Bernard)

Name of Organization & Intake Phone Number	Services Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705-X 2 Vietnamese 800-960-7705-X 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protection Investigation Orleans 504-680-9000 Jefferson East & St. Bernard 504-736-7033 Jefferson West & Placquemine 504-361-6161 **STATE HOT LINE** 855-4LA-KIDS 855-452-5437 www.dss.state.la.us	Investigates child abuse and neglect; Validates claims	Ages birth through age 18	No
Children's Special Health Services Family Resource Center 504-896-1340 Fax 504-896-1360 www.dhh.louisiana.gov (Type in "Children's Special Health Services")	Information & Referral; Peer to peer support; Care coordination	None	No
Dental Services 225-342-4182 Medicaid Dental 877-455-9955 www.dhh.louisiana.gov (Type in "dental services – Medicaid")	Dental Care 21 & younger	Medicaid Eligible	No
Dept. of Education (Child Search) Orleans 504-304-4988 www.nops.k12.la.us Jefferson - East Bank 504-736-1836 West Bank 504-544-6028 Plaquemine 504-595-6052 St. Bernard 504-301-2000x143 www.louisianaschools.net/lde/pair/1213.html	Developmental Screening 3 – 5 years; Special Ed Preschool; Provide Therapies (ST, OT, PT)	3 to 21 years old	No

Name of Organization & Intake Phone Number	Services Provided	Eligibility Criteria	Physician Referral
Early Childhood Support Services www.ecssla.org 504-483-1821	Infant MH 0 - 5 yr	Self Referral	No
Early Steps Orleans, St. Bernard , Placquemine 504-595-3408 Jefferson 504-496-0165 www.eikids.com (Type in “contacts”) or http://new.dhh.louisiana.gov/index.cfm/page/139/n/139	Developmental Screening and Early intervention; Provide therapies (ST, OT, PT)	0 to 3 years old	No
Emergency/Disaster Am Red Cross 800-229-8191 www.arcno.org United Way 504-822-5540 www.unitedwaynola.org Federal/State Dept Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency relief Vietnamese/ Spanish Evacuation guides 24 hr hot line-SSI WIC, Medicaid Food Stamps	No out of pocket cost Financial Criteria	No
Families Helping Families FHF SE La: 504-943-0343 877-243-7352 www.fhfsela.org FHF Jefferson: 504-888-9111 800-766-7736 www.fhfjefferson.org Family 2 Family Health Information Center www.blfhf.org/f2fhic/index 800-331-5570	Information & Referral; Education & Training; Peer to peer support	No out of pocket cost	No
Food Stamps (SNAP) 504-599-1700 Orleans/St. Bernard 888-524-3578 www.dss.la.gov	Food Stamps	Financial Criteria	No

Information provided by Louisiana Children’s Special Health Services (CSHS) 6/2011

www.dhh.louisiana.gov

Name of Organization & Intake Phone Number	Services Provided	Eligibility Criteria	Physician Referral
LSU Behavioral Sciences Center 504-412-1580 or 504-412-1581 www.lsuhn.com/locations	Mental Health & Addictive Disorders ages 0 - adult	Self Referral	No
Medicaid Enrollment Line **La Chip** 877-252-2447 www.lachip.org	Health Insurance 24 hours automated service;	Financial Criteria La MOMS - Pregnancy	No

Name of Organization & Intake Phone Number	Services Provided	Eligibility Criteria	Physician Referral
La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Vietnamese /Spanish spoken	and up to 60 days post partum	
Medicaid Medical Transportation (non-emergency) 800-836-9587 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to & from medical appointments Transports parent and child	Medicaid Eligible	No
Metropolitan Human Service Dist. (MHSD/DDS - OCDD related services)* www.mhsdla.org 504-599-0245 (MHSD – Mental Health) 504-568-3130 www.dhh.louisiana.gov (Type in "Metropolitan human service district") Jefferson Parish Human Service Authority (JPHSA – OCDD related services)* 504-838-5357 www.jphsa.org (JPHSA – Mental Health) 504-349-8833 After hours: 504-832-5123 * from birth to 3 – see also Early Steps	Cash subsidy; Early Intervention; Extended Family Living; ICF/DD Residential Services; Individual and Family Support; Support Coordination; Supported Living; Transition, Vocational & Rehabilitative Services; Waivers Mental Health Services; Addictive Disorders	Ages 3 and up For OCDD – Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	No For OCDD MD to sign forms during enrollment process
Personal Care Services - EPSDT (KIDMED referral asst. hotline) 877-455-9955 www.la-kidmed.com	Personal Care Services	Medicaid Eligible 0 - 21 years of age Medical Criteria	No Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Ass't 888-477-2669 www.pparxla.org St. Vincent De Paul 504-940-1904 ext 7 Wal-Mart www.walmart.com Walgreens www.walgreens.com Target www.target.com	Find prescription medications for people in need Monday/ Wednesday 8-10 en Espanol $4/30 day supply	Fees based on out of pocket cost _____ No out of pocket for those without insurance	No
Shriners Hospitals for Children (Orthopedic Services) **Shreveport** 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of pocket cost - must keep appointments	Diagnosis from physician
Social Security Income/Disability 800-772-1213 www.ssa.gov	Income for disabled **Reapply** if denied	Medical Criteria	Diagnosis from physician
Women Infants and Children (WIC) 800-251-2229 www.dhh.louisiana.gov	Food and formula vouchers	Must keep MD	MD to sign application/

Name of Organization & Intake Phone Number	Services Provided	Eligibility Criteria	Physician Referral
(Type in "WIC")	WIC Healthy Baby Line	appointments	referral

Most State and Federal Programs are based on: Financial eligibility (poverty indices) and/or diagnoses. When in doubt – refer to the agency and they will determine eligibility.

Information provided by Louisiana Children's Special Health Services (CSHS) 6/2011

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705- X 2 Vietnamese 800-960-7705- X 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protection Investigation Ascension 800-861-4589 Baton Rouge East 225-925-4571 West 225-687-4373 Feliciana, East/West 225-683-3734 Iberville 225-687-4373 Pointe Coupe 225-638-4846 STATE HOT LINE 855-4LA-KIDS 855-452-5437 www.dss.state.la.us	Investigates child abuse and neglect; Validates claims	Ages birth through age 18	No
Capital Area Human Services Dist.* (CASHD - OCDD related services) 225-925-1910 866-628-2133 www.cahsd.org/08homeDDFrameset.html (CASHD – **Mental Health** Services) 225-922-0445 www.dhh.louisiana.gov www.lsuhn.com/locations * for ages 0-3 – see also Early Steps	Cash subsidy; Early Intervention; Extended Family Living; ICF/DD Residential Services; Support; Support Coordination; Supported Living; Transition, Vocational & Rehabilitative Services; Waiver Services Mental Health; Addictive Disorders	Ages 3 and up For OCDD – Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	No MD to sign form during enrollment process
Children's Special Health Services 225-242-4890 www.dhh.louisiana.gov (Type in "Children's Special Health Services")	Regional sub-specialty clinics and care coordination	Financial Criteria; medical criteria for certain diagnosis and conditions	Yes - provide diagnosis on a prescription
Dental Services 225-342-4182 Medicaid Dental877-455-9955	Dental Care		

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
www.dhh.louisiana.gov (Type in "dental services – Medicaid")	21 & younger	Medicaid Eligible	No
Dept. of Education - Exceptional Children (Child Search) 225-929-8600 http://specialed.ebrschools.org/explore.cfm/glossary www.louisianaschools.net/lde/pair/1213.html	Developmental Screening; Ages 3 – 5 years Special Ed preschool; Provide therapies (ST, OT, PT)	3 to 21 years old	No
Early Steps SE LA Area Health Edu. Center 225-925-2426 866-925-2426 www.laeikids.com (Type in "contacts")	Developmental screening and early intervention Provide therapies (ST, OT, PT)	0 to 3 years old	No
Emergency/Disaster Am Red Cross 800-229-8191 www.arcbatonrouge.org Capital Area United Way 225-383-2643 www.cauw.org Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency relief Vietnamese/ Spanish Evacuation guides 24 hr hot line-SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	No

Individual and Family

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
~~Families Helping Families of Greater~~ Baton Rouge 866-216-7474 www.fhfgbr.org Family 2 Family Health Information Center 800-331-5570 www.blfhf.org/f2fhic/index	Information ~~& Referral;~~ Education & Training; Peer to peer support	No out of pocket cost	No
Food Stamps (SNAP) 888-LAHELPU 888-524-3578 www.dss.la.gov	Food Stamps	Financial Criteria	No
Louisiana Federation of Families 225-293-3508 800-224-4010 www.laffcmh.org Early Childhood Support Services (ECSS) 225-219-4900 www.ecssla.org	Mental Health (MH) & Addictive Disorders ages 0 – adult Infant MH 0 - 5yr	Self Referral Self Referral	No
Medicaid Enrollment Line		Financial Criteria	

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
La CHIP 877-2-LACHIP 877-252-2447 www.lachip.org La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours automated service Vietnamese/ Spanish spoken	La MOMS- Pregnancy and up to 60 days post partum	No
Medicaid Medical Transportation (non-emergency) 800-259-1944 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to and from medical appointments; Transports parent/ child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral asst. hotline) 877-455-9955 225-342-9485 www.la-kidmed.com	Personal Care Services	Medicaid Eligible Ages 0 - 21 Medical Criteria	No Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Ass't 888-477-2669 www.pparxla.org St. Vincent De Paul 504-940-1904 Wal-Mart www.walmart.com Walgreens www.walgreens.com Target www.target.com	Find prescription medications for people in need en Espanol $4/30 day supply	Fees based on out of pocket cost No out of pocket cost for those without insurance	No
Shriners Hospitals for Children (Orthopedic Services) Shreveport 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of cost, must keep appointments	Diagnosis from physician
Social Security Income/Disability 800-772-1213 www.ssa.gov	Income for disabled Reapply if denied	Medical Criteria	Diagnosis from physician
Women Infants and Children (WIC) 800-251-2229 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line	Must keep MD appointments	Yes MD to sign application/ referral

Most State and Federal Programs are based on: Financial eligibility (poverty indices) and/or diagnoses. When in doubt – refer to the agency and they will determine eligibility.

RESOURCES for MEDICAL HOME CARE COORDINATION Region 3

The parishes of Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary and Terrobonne)

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705	Legal assistance;		

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Spanish 800-960-7705 ext.2 Vietnamese 800-960-7705 ext.3 www.advocacyla.org/priorities.php	Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protection Investigation Assumption/Lafourche 866-461-6278 St. Charles/St. James 800-731-6801 St. John 800-431-6801 St. Mary 800-844-6508 Terrebonne 985-857-3634 **STATE HOT LINE** 855-4LA-KIDS 855-452-5437 www.dss.state.la.us	Investigates child abuse and neglect; Validates claims	Ages birth through age 18	No
Bayou Supports and Services Center Now known as: South Central LA Human Service Authority (OCDD related services) 985-449-5167 www.dhh.louisiana.gov (type in "South Central LA human service authority)	Community Support; Residential Programs; A Resource Center for Medical, Dental supports in collaboration with Greater New Orleans Supports and Services Center providing psychiatric services; Supported Independent & Extended Family living	Self Referral For OCDD – Medical Criteria- Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	No MD to sign forms during enrollment
Behavioral Health – South Central LA Human Service Authority 985-858-2931 Terrebonne/Lafourche 800-840-7758 St. John, St. James & St. Charles 800-709-2635 St. Mary/Assumption 800-481-6682 South Lafourche 800-655-8719 www.dhh.louisiana.gov (Type in "South Central Human Service Authority Behavioral Health")	Mental Health & Addictive Disorders ages 0 - adult	Self Referral	No
Children's Special Health Services 985-447-0896 www.dhh.louisiana.gov (Type in "children's special health services")	Regional sub-specialty clinics and care coordination	Financial Criteria; Medical criteria for certain diagnosis and conditions	Yes provide Diagnosis on a prescription
Dental Services 225-342-4182 Medicaid Dental877-455-9955 www.dhh.louisiana.gov (type in "dental services – Medicaid")	Dental Services	Medicaid Eligible	No
Dept. of Education Exceptional Children (Child Search)			

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Assumption 985-369-2977 Lafourche 985-447-8181 St. Charles 985-785-6289 St. James 225-265-9011 St. John 985-652-9250 St. Mary 337-828-1767 Terrebonne 985-851-1550 www.louisianaschools.net/lde/pair/1213.html	Developmental Screening; 3 – 5 years Special Ed preschools; Provide therapies (ST, OT, PT)	3 to 21 years old	No
Early Steps SE LA Area Health Education Center 985-447-6550 866-891-9044 www.laeikids.com (Type in "contacts")	Developmental Screening and Early intervention; Therapies (ST, OT, PT)	0 to 3 years old	No

Information provided by Louisiana Children's Special Health Services (CSHS) 6/2011
www.dhh.louisiana.gov

Peer to Peer Support and Training

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Emergency/Disaster Am Red Cross 800-229-8191 www.arcno.org United Way www.uwsla.com Houma 985-879-2461 Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency relief Vietnamese/Spanish Evacuation guides 24 hr hot line-SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	No
Families Helping Families Bayou Land 985-447-4461 800-331-5570 www.blfhf.org Family 2 Family Health Information Center www.blfhf.org/f2fhic/index 800-331-5570	Information & Referral; Education	No out of pocket cost	No
Food Stamps (SNAP) 888-524-3578 Lafourche 985-447-0938 Terrebonne 985-857-3620 St. Mary 877-276-8308 St Charles 985-758-7135 St John 985-651-2984 St. James 225-869-5371 Assumption 985-369-6134 www.dss.la.gov	Food Stamps	Financial Criteria	No
Medicaid Enrollment Line La CHIP 877-252-2447 www.lachip.org La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours automated service Vietnamese/ Spanish spoken	Financial criteria La MOMS- Pregnancy and up to 60 days post partum	No
Medicaid Medical Transport (non-			

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
emergency) Lafourche, Assumption & Terrebonne 800-259-1944 St. John, St. James, St. Charles 800-836-9587 St. Mary 337-828-5779 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to and from medical appointments; Transports parent and child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral assistance hotline) www.la-kidmed.com 877-455-9955	Personal Care Services	Medicaid eligible ages 0 - 21 Medical Criteria	No Forms signed during enrollment
Pharmacy Assistance 888-477-2669 Partnership for Prescription Assistance www.pparxla.org Wal-Mart www.walmart.com Walgreens www.walgreens.com Target www.target.com	Find prescription medications for people in need $4/30 day supply	Fees based on out of pocket cost	No
Shriners Hospitals for Children (Orthopedic Services) **Shreveport** 318-222-5704 www.shrinershospitals.org	Orthopedic conditions Surgery; Therapy; Equipment	No out of pocket cost, must keep appointments	Diagnosis from physician
Social Security Disability/SSI Lafourche, Houma 866-899-5631 St. Mary, Assumption 985-384-5301 St. Charles/St. John 800-772-1213 St. James 866-613-3070 www.ssa.gov Nat'l# 800-772-1213	Income for disabled Reapply if denied	Medical Criteria	Diagnosis from physician
Women Infants and Children Assumption 985-369-6031 Lafourche 985-447-0921 Terrebonne 985-857-3601 St. Mary 985-380-2441 St. Charles 985-785-2314 St. James 225-869-3005 St. John 985-536-2172 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	Yes MD to sign application/ referral

RESOURCES for MEDICAL HOME - CARE COORDINATION Region 4

(The parishes of: Acadia; Evangeline; Iberia; Lafayette; St. Landry; St. Martin; Vermillion)

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705 ext. 2 Vietnamese 800-960-7705 ext. 3	Legal assistance; Patient rights; Legal representation	Funded by the state for persons elderly	No

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
www.advocacyla.org/priorities.php	at no cost to families	or with disabilities	
Child Protection Investigation All parishes in Region 4 800-844-6508 STATE HOT LINE 855-4LA-KIDS 855-452-5437 www.dss.state.la.us	Investigates child abuse and neglect; Validates claims	Ages birth through age 18	No
Behavioral Health Region 4 Acadia 337-788-7511 Lafayette, St. Martin, Vermillion 337-262-4100 St. Landry 337-948-0226 Iberia 337-373-0002 Evangeline 337-363-5525 www.dhh.louisiana.gov (Type in "Behavioral Health Region 4") Early Childhood Support Services **(ECSS)** 337-262-1226 www.ecssla.org	Mental Health & Addictive Disorders ages 0 – adult Infant Mental Health 0 – 5 years	Self Referral	No
Children's Special Health Services 337-262-5616 Ext 6 www.dhh.louisiana.gov (Type in "children's special health services")	Regional sub-specialty clinics & care coordination	Financial Criteria; medical criteria for certain diagnosis and conditions	Yes Provide diagnosis on a prescription
Dental Services 225-342-4182 Medicaid Dental 877-455-9955 www.dhh.louisiana.gov (Type in "dental services – Medicaid")	Dental Services	Medicaid Eligible	No
Dept. of Education - Exceptional Children (Child Search) 877-453-2721 www.louisianaschools.net/lde/pair/1213.html	Developmental Screening; Special Ed preschools; Provide therapies (OT, PT, ST)	3 to 21 years old	No
Early Steps 866-494-8900 Mary Hockless 337-359-8748 teamfsrc@bellsouth.net www.laeikids.com (Type in "contacts")	Developmental Screening & Early Intervention; Provide therapies (SP, OT, PT)	0 to 3 years old	No
Emergency/Disaster Am Red Cross 337-234-7371 www.acadianaredcross.org United Way 337-233-8302 www.unitedwayofacadiana.org Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency Relief Vietnamese/ Spanish Evacuation guides 24 hr hot line - SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	No
Families Helping Families of Acadiana 800-378-9854 337-984-3458 www.fhfacadiana.com Family 2 Family Health Information Center 800-331-5570	Family advocate for Special Ed issues; Workshops; Resources	No out of pocket cost	No

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
www.blfhf.org/f2fhic/index			

Information provided by Children's Special Health Services (CSHS) 6/2011
www.dhh.louisiana.gov

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Food Stamps (SNAP) 337-373-0060 888-LAHELPU 888-524-3578 www.dss.la.gov	Food Stamps	Financial Criteria	No
Medicaid Enrollment Line La CHIP 877-252-2447 La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours automated service Vietnamese/ Spanish spoken	Financial Criteria La MOMS- Pregnancy and up to 60 days post partum	No
Medicaid Medical Transportation (non-emergency) 800-864-6034 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to and from medical appointments; Transports parent and child	Medicaid Eligible	No
Personal Care Services - EPSDT (KIDMED referral asst. hotline) 877-455-9955 225-342-9485 www.la-kidmed.com	Personal Care Services	Medicaid Eligible Ages 0 - 21 Medical Criteria	No Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Assistance www.pparxla.org 888-477-2669 Wal-Mart www.walmart.com Walgreens www.walgreens.com Target www.target.com	Find prescription medications for people in need $4/30 day supply	Fees based on out of pocket cost None	No
Region 4 Community Services Office* (OCDD related services) 337-262-5610 800-648-1484 www.dhh.louisiana.gov (Type in Community Services Office Region	Cash Subsidy; Extended Family Living (EFL); ICF/DD Residential Services; Individual and Family Support; Support coordination; Supported living; Transition,	Ages 3 and up For OCDD - Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	No MD to sign forms during enrollment

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
4") *from birth to 3 – see also Early Steps	Rehabilitative, & Vocational Services; Waivers		process
Shriners Hospitals for Children (Orthopedic services) Shreveport 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of pocket cost, must keep appointments	Diagnosis from physician
Social Security Disability & (SSI) **Hotline:** 800-772-1213 www.ssa.gov	Income for disabled Reaply if denied	Medical Criteria	No - Diagnosis from physician
Women Infants and Children (WIC) 800-251-2229 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	MD to sign application/ referral

RESOURCES for MEDICAL HOME CARE COORDINATION Region 5

(The parishes of: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis)

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705 ext. 2 Vietnamese 800-960-7705 ext. 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protection Investigation Allen 318-335-1942 Beauregard 318-463-2056 Calcasieu/Cameron 337-491-2470 Jefferson Davis 337-824-9649 STATE HOT LINE 855-4LA-KIDS 855-452-5437 www.dss.state.la.us	Investigates child abuse and neglect; Validates claims	Ages birth through age 18	No
Behavioral Health Region 5 24 hour hot line 800-272-8367 Beauregard 337-462-1641 Allen 337-639-3001 Calcasieu, Cameron, Jeff Davis 337-475-8022 www.dhh.louisiana.gov (Type in "Behavioral Health – Region 5")	Mental Health & Addictive Disorders ages 0 - adult	Self Referral	No
Children's Special Health Services		Financial Criteria;	Yes Provide

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
337-480-2552 www.dhh.louisiana.gov (Type in "Children's Special Health Services")	Regional sub-specialty clinics and care coordination	Medical criteria for certain diagnosis and conditions	diagnosis on a prescription
Dental Services children 225-342-4182 Medicaid Dental877-455-9955 www.dhh.louisiana.gov (Type in "dental services – Medicaid")	Dental Services	Medicaid Eligible	No
Dept. of Education - Exceptional Children (Child Search) 877-453-2721 Allen 337-639-2996 Beauregard 337-463-4534 Calcasieu 337-217-4300 Cameron 337-775-5784 Jefferson Davis 337-824-1357 www.louisianaschools.net/lde/pair/1213.html	Developmental Screening; 3 – 5 years Special Ed preschools; Provide therapies (ST, OT, PT)	3 to 21 years old	No
Early Steps 337-359-8748 **Mary Hockless** teamfsrc@bellsouth.net 866-494-8900 www.laeikids.com (Type in "contacts")	Developmental Screening and early intervention; Provide therapies (ST, OT, PT)	0 to 3 years old	No
Emergency/Disaster 800-229-8191 Am Red Cross 337-478-5122 www.arc.org or www.swla-redcross.org United Way 337-433-1088 www.unitedwayswla.org Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency Relief Vietnamese/ Spanish Evacuation guides 24 hr hot line - SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	No

Information provided by Children's Special Health Services (CSHS) 6/2011
www.dhh.louisiana.gov

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Families Helping Families of SW LA 800-894-6558 337-436-2570 www.fhfswla.org Family 2 Family Health Information Center 800-331-5570 www.blfhf.org/f2fhic/index	Information & Referral; Education & Training; Peer to peer support	No out of pocket cost	No
Food Stamps (SNAP) 888-LAHELPU 888-524-3578 www.dss.la.gov	Food Stamps	Financial Criteria	No
Louisiana Federation of Families 225-293-3508 800-224-4010 www.laffcmh.org	Mental Health & Addictive Disorders ages 0 - adult	Self Referral	No
Medicaid Enrollment Line La CHIP 877-252-2447 www.lachip.org La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours automated service Vietnamese/ Spanish spoken	Financial Criteria La MOMS - Pregnancy and up to 60 days post partum	No
Medicaid Medical Transportation 800-864-6034 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	No cost transportation (cab) to/from medical appointments; Transports parent/child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral assistance hotline) 877-455-9955 225-342-9485 www.la-kidmed.com	Personal Care Services	Medicaid Eligible Ages 0 - 21 Medical Criteria	No Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Assistance www.pparxla.org 888-477-2669 Wal-Mart www.walmart.com Walgreens www.Walgreens.com Target www.target.com	Find prescription medications for people in need $4/30 day supply	Fees based on out of pocket cost	No
Region 5 - Community Services Office* (OCDD – related services) 337-475-8045 800-631-8810 www.dhh.louisiana.gov (Type in "Community Services Office Region 5 ") **Mental Health Services** 337-475-8022 www.dhh.louisiana.gov (Type in "Mental Health Services	Cash Subsidy; Extended Family Living; ICF/DD Residential services; Individual & Family support; Support Coordination; Supported living; Vocational, Rehabilitation, & Transition Services Mental Health Services	Ages 3 and up For OCDD - Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	No MD to sign forms during enrollment process

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Region 5") *from birth to 3 – see also Early Steps	Addictive Disorders		
Shriners Hospitals for Children (Orthopedics) **Shreveport** 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of pocket cost, must keep appointments	Diagnosis from physician
Social Security Income/Disability www.ssa.gov 800-772-1213 Allen & Beauregard 337-463-4436 Calcasieu, Cameron, Jeff Davis 877-409-8431	Income for disabled **Reapply,** if denied	Medical Criteria	Diagnosis from physician
Women Infants and Children (WIC) 800-251-2229 Allen 337-335-1147 Beauregard 337-463-4486 Calcasieu 337-478-6020 Cameron 337-775-5368 Jefferson Davis 337-824-2193 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	Yes MD to sign application/ referral

Most State and Federal Programs are based on: Financial eligibility (poverty indices) and/or diagnoses. When in doubt – refer to

RESOURCES for MEDICAL HOME CARE COORDINATION Region 6

(The parishes of: Avoyelles; Catahoula; Concordia; Grant; La Salle; Rapides; Vernon; Winn)

Name of Organization &Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705 ext. 2 Vietnamese 800-960-7705 ext. 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protection Investigation Avoyelles 866-426-8871 Catahoula/ Concordia 866-429-8871 LaSalle/Rapides 866-429-8871 Grant /Vernon/Winn 800-551-8383 STATE HOT LINE 855-4LA-KIDS 855-452-5437 www.dss.state.la.us	Investigates child abuse and neglect; Validates claims	Ages birth through age 18	No
Children's Special Health Services 318-487-5282 Parent Liaison 318-487-5282 www.dhh.louisiana.gov (Type in "Children's Special Health Services")	Regional sub-specialty clinics and care coordination	Financial Criteria; medical criteria for certain diagnosis and conditions	Yes Provide diagnosis on a prescription
Dental 225-342-4182 Medicaid Dental877-455-9955 www.dhh.louisiana.gov (Type in "dental services – Medicaid")	Dental services	Medicaid Eligible	No
Dept. of Education - Exceptional Children (Child Search) Rapides 318-443-4572 *www.rapides.k12.la.us/childsearch/* Grant 318-627-5944 Avoyelles 318-876-2811 LaSalle 318-992-5971 Catahoula 318-744-5727 Concordia 318-336-5177 Winn 318-628-3913 Vernon 337-239-1689 www.louisianaschools.net/lde/pair/1213.html	Developmental Screening; 3 – 5 years Special Ed preschools; Provide Therapies (ST, OT, PT)	3 to 21 years old	No
Early Steps 318-640-7078 Fax 318-640-5799 866-445-7672 www.laeikids.com (Type in "contacts")	Developmental screening; Early intervention; Provide therapies (ST, OT, PT)	0 to 3 years old	No
Emergency/Disaster Am Red Cross 800-229-8191			

Name of Organization &Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
318-442-6621 www.cenlaredcross.org www.arc.org United Way 318-443-7203 www.uwcl.org Federal/State Dept of Social Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency relief Vietnamese/ Spanish Evacuation guides 24 hr hot line-SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	No

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Families Helping Families Crossroads of LA 318-641-7373 800-259-7200 www.familieshelpingfamilies.net Family 2 Family Health Information Center www.blfhf.org/f2fhic/index 800-331-5570	Information & Referral; Education & Training; Peer to peer support	No out of pocket cost	No
Food Stamps (SNAP) Rapides Parish 318-487-5101 888-LAHELPU 888-524-3578 www.dss.la.gov	Food Stamps	Financial Criteria	No
LSU Behavioral Center ~~24 hr. crisis line 877-500-9997~~ www.dhh.louisiana.gov (Type in "LSU Behavioral Health")	Mental Health Services Addictive Disorders Age 0 - adult	Referrals to MH or substance abuse outpatient services are self referral	No
Medicaid Enrollment Line La CHIP 877-252-2447 La MOMS, TAKE CHARGE www.lamedicaid.com 888-342-6207	Health Insurance 24 hours automated service Vietnamese/ Spanish spoken	Financial Criteria La MOMS - Pregnancy and up to 60 days post partum	No
Medicaid Medical Transportation (non-emergency) 800-446-3490 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to/from medical appointments; Transports parent and child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral - hotline) 877-455-9955 225-342-9485 www.la-kidmed.com	Personal Care Services	Medicaid Eligible 0 - 21 years of age Medical Criteria	No Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Ass't. www.pparxla.org 888-477-2669 Walgreens www.walgreens.com Wal-Mart	Find prescription medications for people in need	Fees based on out of pocket cost	No

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
www.walmart.com Target www.target.com	$4/30 day supply		
Region 6 Community Services Offices OCDD related services* 318-484-2347 800-640-7494 www.dhh.louisiana.gov (Type in "Community Services Offices Region 6") **Region 6** Mental Health Services after hours 800-654-1373 Avoyelles 318-253-9638 Leesville 337-238-6431 Pineville 318-484-6850 www.dhh.louisiana.gov (Type in "Mental Health") *from birth to 3 – see Early Steps	OCDD - Cash Subsidy; Extended Family Living (EFL); ICF/DD Residential Services; Individual and Family Support; Support coordination; Supported living; Transition, Rehabilitative & Vocational services; Waiver services Mental Health Services; Addictive Disorders	Ages 3 and up; For OCDD - Autism; Mental Retardation; Cerebral Palsy (severe); Epilepsy (severe)	No MD to sign forms during enrollment
Shriners Hospitals for Children (Orthopedics) **Shreveport** 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of pocket cost, must keep appointments	Diagnosis from physician
Social Security Disability/SSI 318-445-0549 800-772-1213 www.ssa.gov	Income for disabled **Reapply,** if denied	Medical Criteria	Diagnosis from physician
Women Infants and Children WIC 318-487-5282 800-251-2229 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	Yes MD to sign application

Most State and Federal Programs are based on: Financial eligibility (poverty indices) and/or Diagnoses. When in doubt –refer to the agency and they will determine eligibility.

RESOURCES for MEDICAL HOME CARE COORDINATION Region 7

(The parishes of: Bienville; Bossier; Caddo; Claiborne; De Soto; Natchitoches; Red River; Sabine; Webster)

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705 ext. 2 Vietnamese 800-960-7705ext. 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation	Funded by the state for persons elderly or with disabilities at no cost	No
Behavioral Health	Mental Health	Referrals to any MH or	

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
LSU Psychiatry Center 318-813-2450 www.universitypsychiartry.com **Early Childhood Support Services** www.ecssla.org 318-872-2055	Addictive Disorders age 0 – adult 0 – 5yr	substance abuse out-patient services are self referral	No No
Child Protective Investigation Bienville, Claiborne, Webster 318-676-7100 Bossier 318-741-7340 Caddo 318-676-7622 De Soto 318-872-6311 Sabine 318-256-4104 Natchitoches, Red River 318-357-3128 STATE HOT LINE 855-4LA-KIDS 855-452-5437 www.dss.state.la.us/	Investigates child abuse and neglect; Validates claims	0 - 18	No
Children's Special Health Services 318-676-7488 www.dhh.louisiana.gov (Type in "Children's Special Health Services")	Regional sub-specialty clinics and care coordination	Financial Criteria; medical criteria for certain diagnosis and conditions	Yes, Provide diagnosis on a prescription
Dental Services 225-342-4182 Medicaid Dental 877-455-9955 www.dhh.louisiana.gov (Type in "dental services – Medicaid")	Dental services	Medicaid Criteria	No
Dept. of Education - Exceptional Children (Child Search) Caddo 318-603-6702 *foneal@caddo.k12.la.us* www.louisianaschools.net/lde/pair/1213.html	Developmental Screening; Special Ed preschools; Provide therapies (ST, OT, PT)	3 to 21 years old	No
Early Steps 866-676-1695 318-226-8038 Fax 318-425-8295 www.laeikids.com (Type in "contacts")	Developmental Screening and Early intervention; Provide therapies	0 to 3 years old	No
Emergency/Disaster Am Red Cross 318-865-9545 800-229-8191 www.louisianaredcross.org **United Way** 318-677-2504 www.unitedwaynwla.org Federal/State Dept of Soc Service 888-LA HELPU 888-524-3578 www.dss.la.gov	Emergency relief Vietnamese/ Spanish Evacuation guides 24 hr hot line SSI; WIC; Medicaid; Food Stamps	No out of pocket cost No out of pocket cost	No No
Families Helping Families of Northwest LA 318-226-4541 877-226-4541 www.fhfregion7.com Family 2 Family Health Information Center www.blfhf.org/f2fhic/index 800-331-5570	Information & Referral; Education & Training; Peer to peer support	No out of pocket cost	No

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Food Stamps (SNAP) 318-676-7600 Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Food Stamps	Financial Criteria	No
Medicaid Enrollment Line La CHIP 877-252-2447 www.lachip.org La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours automated service Vietnamese/ Spanish spoken	Financial Criteria La MOMS - Pregnancy and up to 60 days post partum	No
Medicaid Medical Transportation (non-emergency) 800-259-7235 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to and from medical appointments; Transports parent and child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral asst. hotline) 877-455-9955 225-342-9485 www.la-kidmed.com	Personal Care Services	0 - 21 years of age Medicaid eligible Parent can enroll	Yes Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Assistance 888-477-2669 www.pparxla.org Walgreens www.walgreens.com Wal-Mart www.walmart.com Target - www.target.com	Find prescription medications for people in need $4/30 day supply	Fees based on out of pocket cost	No
Region 7 Community Services Offices OCDD related services* 318-741-7455 800-862-1409 www.dhh.louisiana.gov (Type in "Community Services Offices Region7") Region 7 - Mental Health Services 318-676-5111 after hrs child - 800-820-6143 adult 866- 416-5370 www.dhh.louisiana.gov (Type in "Mental Health Services Offices Region7") *from birth to 3 – see Early Steps	OCDD - Cash subsidy; Individual & Family Support; Support Coordination; Supported living; Vocational, Rehabilitative & Transition Services Mental Health Services Addictive Disorders	Ages 3 and up; For OCDD - Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	Yes MD to sign forms during enrollment
Shriners Hospitals for Children (Orthopedic services) Shreveport 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of pocket cost, must keep appointments	Diagnosis from physician
Social Security Disability/SSI 318-869-6400 800-772-1213 Bienville, Claiborne, Webster 877-314-5762	Income for disabled		Diagnosis from

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Caddo, Bossier, De Soto 877-319-3074 Natchitoches, Red River, Sabine 318-357-1818 www.ssa.gov	**Reapply,** if denied	Medical Criteria	physician
Women Infants and Children (WIC) 318-676-5268 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	Yes MD to sign application/ referral

Most State and Federal Programs are based on: Financial eligibility (poverty indices) and/or Diagnoses. When in doubt – refer to the agency and they will determine eligibility.

RESOURCES for MEDICAL HOME - CARE COORDINATION Region 8

(The Parishes of: Caldwell; East Carroll; Franklin; Jackson; Lincoln; Madison; Morehouse; Ouachita; Richland; Tensas; West Carroll; Union)

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705 ext.2 Vietnamese 800-960-7705 ext. 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protective Investigation Region 8 318-362-3362 **STATE HOT LINE** 855-4LA-KIDS 855-452-5437 www.dss.state.la.us/	Investigates child abuse and neglect; Validates claims	0 - 18	No
Children's Special Health Services Monroe Health Unit 318-361-7282 www.dhh.louisiana.gov Children's Special Health Services	Regional sub-specialty clinics and care coordination	Financial Criteria; medical criteria for certain diagnosis and conditions	Yes Provide diagnosis on prescription
Dental Services 225-342-4182 Medicaid Dental 877-455-9955 www.dhh.louisiana.gov Type in "dental services Medicaid"	Dental Services	Medicaid Eligible	No
Dept. of Education, Louisiana Child Search Caldwell Parish 318-649-6181 City of Monroe 318-388-3747 East Carroll Parish 318-559-3770 Franklin Parish 318-435-9046	Developmental Screening; 3 – 5 years Special Ed preschools;	3 to 21 years old	

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Jackson Parish 318-259-8802 Lincoln Parish 318-251-9082 Madison Parish 318-574-4005 Morehouse Parish 318-283-1674 Ouachita Parish 318-338-2541 Richland Parish 318-728-5964 Tensas Parish 318-766-3791 Union Parish 318-368-9715 ext. 129 West Carroll Parish 318-428-4215 www.louisianaschools.net/lde/pair/1213.html	Provide Therapies (ST, OT, PT)		No
Early Steps Easter Seals of LA 318-322-4788 877-322-4788 Patti Hankins 318-362-5197 www.laeikids.com (Type in "contacts")	Developmental Screening and Early intervention; Provide Therapies (ST, OT, PT)	0 to 3 years old	No
Emergency/Disaster Am Red Cross 888-323-5141 www.nelaredcross.org United Way 318-325-3869 www.uwnela.org Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency relief Vietnamese/ Spanish Evacuation guides 24 hr hot line-SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	 No
Families Helping Families Northeast LA 318-361-0487 www.fhfnela.org 888-300-1320 Family 2 Family Health Information Center www.blfhf.org/f2fhic/index 800-331-5570	Information & Referral; Education & Training; Peer to peer support	No out of pocket cost	No
Food Stamps (SNAP) www.dss.la.gov Caldwell 318-649-2673 East Carroll 318-559-2904 Franklin 318-435-2101 Jackson 318-259-2411 Lincoln 318-251-4105 Madison 318-574-1913 Morehouse 318-283-0825 Ouachita, Richland, Union 318-362-5333 Tensas 318-749-3234 West Carroll 318-428-3252	Food Stamps	Financial Criteria	No

Name of Organization & Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Medicaid Enrollment Line La CHIP 877-252-2447 La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours service Vietnamese/ Spanish spoken	Financial Criteria La MOMS – Pregnancy/up to 60 days post partum	No
Medicaid Medical Transportation (non-emergency) 800-259-1835 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) for medical appointments; Transports parent and child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral asst. hotline) 877-455-9955 225-342-9485 www.la-kidmed.com	Personal Care Services	0 - 21 years of age Medicaid Eligible Parent can enroll	No - Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Assistance www.pparxla.org 888-477-2669 Walgreens www.walgreens.com Wal-Mart www.walmart.com Target www.target.com	Find prescription medications for people in need $4/30 day supply	Fees based on out of pocket cost No Spanish spoken	No
Region 8 Community Services Office (OCDD Related Services)* 318-362-3396 800-637-3113 www.dhh.louisiana.gov (Type in "Community Services Office Region 8") Region 8 Mental Health Services 318-362-3339 after hrs:800-256-2522 Jonesboro MH 318-259-6624 Richland MH 318-728-6456 Ruston MH 318-251-4150 Tallulah MH 318-574-1713 Winnsboro MH 318-435-2147 www.dhh.louisiana.gov (Type in "Mental Health Services Region 8") Early Childhood Support Services (ECSS) 318-878-3378 www.ecssla.org *from birth to 3 – see Early Steps	Cash subsidy; Extended family living; ICF/DD Residential services; Individual & Family Support; Support Coordination; Supported living; Vocational, Rehabilitation, & Transitional Services Mental Health Services; Addictive Disorders Infant Mental Health 0 – 5 years	Ages 3 and up For OCDD - Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy (severe)	No MD to sign forms during enrollment
Shriners Hospitals for Children (Orthopedic Services) **Shreveport** 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No out of pocket cost, must keep appointments	Diagnosis from physician
Social Security Disability/SSI 318-387-2151 800-772-1213	Income for disabled	Medical Criteria	Diagnosis from

www.ssa.gov	Reapply, if denied		physician
Women Infants and Children WIC Caldwell Parish 318-649-2393 East Carroll Parish 318-559-2012 Franklin Parish 318-435-2143 Jackson Parish 318-259-6601 Lincoln Parish 318-251-4120 Madison Parish 318-574-3311 Morehouse Parish 318-283-0806 Ouachita Parish 318-361-7281 Richland Parish 318-728-4441 Tensas Parish 318-766-3515 Union Parish 318-368-3156 West Carroll Parish 318-428-9361 www.dhh.louisiana.gov (Type in "WIC")	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	Yes MD to sign application/ referral

REOURCES for MEDICAL HOME CARE COORDINATION Region 9

(The Parishes of: Livingston; St. Helena; St. Tammany; Tangipahoa; Washington)

Name of Organization Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Advocacy Center 800-960-7705 Spanish 800-960-7705 ext. 2 Vietnamese 800-960-7705 ext. 3 www.advocacyla.org/priorities.php	Legal assistance; Patient rights; Legal representation at no cost to families	Funded by the state for persons elderly or with disabilities	No
Child Protective Investigation Livingston 225-686-7257 St. Helena 985-748-2001 St. Tammany 985-893-6225 Tangipahoa 985-748-2001 Washington 985-732-6800 STATE HOT LINE 855-4LA-KIDS 855-452-5437 www.dss.state.la.us/	Investigates child abuse and neglect; Validates claims	0 - 18	No
Children's Special Health Services www.dhh.louisiana.gov 985-543-4165 (Type in "Children's Special Health Services")	Regional sub-specialty clinics and care coordination	Financial/medical criteria for certain diagnosis and conditions	Yes - Provide diagnosis on a prescription
Dental Services 225-342-4182 Medicaid Dental 877-455-9955 www.dhh.louisiana.gov (Type in "Dental Services Medicaid)	Dental Services	Medicaid Criteria	No
Dept. of Education Louisiana Child Search – Special Education Livingston 225-667-2080	Developmental Screening; Special Ed	3 to 21 years old	

Name of Organization Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
St. Helena 225-222-4349 St. Tammany 985-898-3323 Tangipahoa 985-310-2122 Washington 985-839-6006 www.louisianaschools.net/lde/pair/1213.html	preschool; 3 – 5 years - Provide Therapies (ST, OT, PT)		No
Early Childhood Support Services www.ecssla.org 985-624-4140	Infant Mental Health 0 – 5 years	Self referral	No
Early Steps 985-429-1252 866-640-0238 www.laeikids.com (Type in "contacts")	Developmental Screening and Early intervention; Provide Therapies (ST, OT, PT)	0 to 3 years old	No
Emergency/Disaster **Am Red Cross** 800-229-8191 www.arcno.org **United Way** 504-822-5540 Ask for **North shore** www.unitedwaynola.org Federal/State Dept of Soc Service 888-LAHELPU 888-524-3578 www.dss.la.gov	Emergency relief; Vietnamese/ Spanish Evacuation guides 24 hr hot line – SSI; WIC; Medicaid; Food Stamps	No out of pocket cost Financial Criteria	No
Families Helping Families, Northshore LA 985-875-0511 800-383-8700 www.fhfnorthshore.org Family 2 Family Health Information Center www.blfhf.org/f2fhic/index 800-331-5570	Information & Referral; Education & Training; Peer to peer support	No out of pocket cost	No
Florida Parishes Human Services Authority **(FPHSA)* (OCDD** related services) 800-866-0806 www.dhh.louisiana.gov (Type in "Florida Parishes Human Services Authority") FPHSA – Mental Health Services 985-748-2220 after hrs:866-847-2652 www.dhh.louisiana.gov (Type in "Florida Parishes Mental Health Services") *from birth to 3 – see Early Steps	Cash subsidy; Early Intervention; Early steps; Extended family living; ICF/DD Residential services; Individual & Family Support; Support Coordination; Supported living; Transition Services Mental Health Services; Addictive Disorders	Ages 3 and up; for OCDD - Autism, Mental Retardation, Cerebral Palsy (severe), Epilepsy-severe	No MD to sign forms during enrollment process

Name of Organization Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
Food Stamps (SNAP) Livingston 225-686-2261 St. Helena 225-222-6155 St. Tammany 985-893-6215 Tangipahoa 985-748-2084 Washington 985-732-6622 www.dss.la.gov	Food Stamps	Financial Criteria	No
Medicaid Enrollment Line La CHIP 877-252-2447 La MOMS, TAKE CHARGE 888-342-6207 www.lamedicaid.com	Health Insurance 24 hours service Vietnamese/ Spanish spoken	Financial Criteria La MOMS - Pregnancy and up to 60 days post partum	No
Medicaid Medical Transportation (non-emergency) 800-259-1944 www.dhh.louisiana.gov (Type in "Medicaid medical transportation")	Transportation (cab) to and from medical appointments Transports parent and child	Medicaid Eligible	No
Personal Care Services EPSDT (KIDMED referral asst. hotline) 877-455-9955 255-342-9485 www.la-kidmed.com	Personal Care Services	0 - 21 years of age Medicaid Eligible Parent can enroll	No Forms signed during enrollment
Pharmacy Assistance Partnership for Prescription Assistance 888-477-2669 www.pparxla.org Wal-Mart www.walmart.com Walgreens www.walgreens.com Target www.target.com	Find prescription medications for people in need $4/30 day supply	Fees based on out of pocket cost	No
Shriners Hospitals for Children (Orthopedic services) **Shreveport** 318-222-5704 www.shrinershospitals.org	Orthopedic conditions; Surgery; Therapy; Equipment	No cost, must keep appointments	Diagnosis from physician
Social Security Disability/SSI Livingston, Tangipahoa, St. Helena 985-345-0335 St. Tammany 866-887-8997 Washington 888-748-7678 www.ssa.gov 800-772-1213	Income for disabled Reapply, if denied	Medical Criteria	Diagnosis from physician
Women Infants and Children WIC Livingston 225-686-7017 St. Helena 225-222-6176 St. Tammany 985-847-0720 Tangipahoa 985-543-4165 Washington 985-839-5646 www.dhh.louisiana.gov (Type in	Food and formula vouchers WIC Healthy Baby Line 800-251-2229	Must keep MD appointments	Yes MD to sign application/ referral

Name of Organization Intake Phone Number	Service Provided	Eligibility Criteria	Physician Referral
"WIC")			

Most State and Federal Programs are based on: Financial eligibility (poverty indices) and/or Diagnoses. When in doubt –refer to the agency and they will determine eligibility.

.

Appendix

Important Definitions

Action	An **action** is defined as: ▪The denial or limited authorization of a requested service, including the type or level of service; or ▪The reduction, suspension, or termination of a previously authorized service; or ▪The denial, in whole or in part, of payment for a service; or failure to provide services in a timely manner
Appeal	an **appeal** is defined as a request for review of an action
Capitation	A fixed per capita amount that LaCare pays monthly to a network provider for each member identified as being in their capitation group, whether or not the member received services.
Case Management Services	Services which will assist individuals in gaining access to necessary medical, social, educational and other services.
Centers for Medicare and Medicaid Services (CMS)	The federal agency within the Department of Health and Human Services responsible for oversight of MA Programs.
Certified Nurse Midwife	An individual licensed or certified per the laws of the State.
Certified Registered Nurse Practitioner (CRNP)	A registered nurse licensed or certified in the State with a particular clinical specialty area and who, while functioning in the expanded role as a professional nurse, performs acts of medical diagnosis or prescription of medical therapeutic or corrective measures in collaboration with and under the direction of a licensed physician or as applicable under state law.
Claim	A bill from a provider of a medical service or product that is assigned a claim reference number. A Claim does not include an Encounter form for which no payment is made or only a nominal payment is made.

Clean Claim	A Claim that can be processed without obtaining additional information from the provider of the service or from a third party. A Clean Claim includes a Claim with errors originating in the MCO's Claims system. Claims under investigation for Fraud or abuse or under review to determine if they are Medically Necessary are not Clean Claims.
Complaint	A verbal or written expression by a provider which indicates dissatisfaction or dispute with CCN policy, procedure, claims processing and/or payment, or any aspect of CCN functions.
Concurrent Review	A review conducted by LaCare during a course of treatment to determine whether the amount, duration and scope of the prescribed services continue to be Medically Necessary or whether a different service or lesser level of service is Medically Necessary.
Cultural Competency	The ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.
Denial of Services	Any determination made by LaCare in response to a request for approval, which: disapproves the request completely; or approves provision of the requested services, but for a lesser amount, scope or duration than requested; or disapproves provision of the requested services, but approves provision of an alternative service(s); or reduces, suspends or terminates a previously authorized service. An approval of a requested service, which includes a requirement for a Concurrent Review by LaCare during the authorized period, does not constitute a Denial of Services.
Denied Claim	An Adjudicated Claim that does not result in a payment to a Provider.

Developmental Disability

A severe, chronic disability of an individual that is:

- Attributable to a mental or physical impairment or combination of mental or physical impairments.
- Manifested before the individual attains age twenty-two (22).
- Likely to continue indefinitely.
- Manifested in substantial functional limitations in three or more of the following areas of life activity:
    - Self care
    - Receptive and expressive language
    - Learning
    - Mobility
    - Capacity for independent living, and
    - Economic self-sufficiency
- Reflective of the individual's need for special, interdisciplinary or generic services, supports, or other assistance that is of lifelong or extended duration, except in the cases of infants, toddlers, or preschool children who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in Developmental Disabilities if services are not provided.

Disease Management

An integrated treatment approach that includes the collaboration and coordination of patient care delivery systems and that focuses on measurably improving clinical outcomes for a particular medical condition through the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling, education and outpatient care; and that includes evaluation of the appropriateness of the scope, setting and level of care in relation to clinical outcomes and cost of a particular condition.

Dispute

A Dispute is a verbal or written expression of dissatisfaction by a network provider regarding a decision that directly impacts the network provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Items and services which must be made available to persons under the age of twenty-one (21) upon a determination of medical necessity and required by federal law at 42 U.S.C. §1396d(r).

Early Intervention System	The provision of specialized services through family-centered intervention for a child, birth to age three (3), who has been determined to have a developmental delay of twenty-five percent (25%) of the child's chronological age or has documented test performance of 1.5 standard deviation below the mean in standardized tests in one or more areas: cognitive development; physical development, including vision and hearing; language and speech development; psycho-social development; or self-help skills or has a diagnosed condition which may result in developmental delay.
Eligibility Period	A period of time during which a member is eligible to receive benefits.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions (or) • Serious dysfunction of any bodily organ or part
Emergency Services	Covered inpatient and outpatients services that: • Are furnished by a Health Care Provider that is qualified to furnish such service under Title XIX of the Social Security Act; and • Are needed to evaluate or stabilize an Emergency Medical Condition.
Encounter	Any health care service provided to a member regardless of whether it has an associated Claim. A Claim form must be created and submitted to LaCare for all Encounters, whether reimbursed through Capitation, fee-for-service, or another method of compensation.

Enrollee	A person eligible to receive services under the Medicaid Program and covered under LaCare.
Enrollment	The process by which a member's coverage is initiated.
Expanded Services	Any Medically Necessary service, covered under Title XIX of the Social Security Act, 42 U.S.C.A. 1396 et seq., but not included in the State's Medicaid Plan, which is provided to members.
Experimental Treatment	A course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.
Family Planning Services	Services that enable individuals voluntarily to determine family size, to space children and to prevent or reduce the incidence of unplanned pregnancies. Such services are made available without regard to marital status, age, sex or parenthood.
Federally Qualified Health Center (FQHC)	An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d(l) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under the above-mentioned sections of the Act.
Formal Provider Appeals	A Formal Provider Appeal is a written request from a Health Care Provider for the reversal of a denial by LaCare, through its Formal Provider Appeals Process. Types of issues addressed through LaCare's Formal Provider Appeals Process are: • Denials based on medical necessity for services already rendered by the Health Care Provider to a member, including denials that: o Do not clearly state the Health Care Provider is filing a member Complaint or Grievance on behalf of a member (even if the materials submitted with the Appeal contain a member consent) or o Do not contain a member consent that conforms with applicable law for a member Complaint or Grievance

	filed by a Health Care Provider on behalf of a member
	Formal Provider Appeals do not include: (a) Claims denied because they were not filed within the 180-day filing time limit; (b) denials issued through the Prior Authorization process; (c) credentialing denials for any reason; and (d) network provider terminations based on quality of care or other for cause reasons.
Fraud	Any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself, or some other person in a managed care setting. Fraud can be committed by many entities, including a contractor, a subcontractor, a Health Care Provider, a State employee, or a member, among others.
Grievance	
	An expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.
	Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.
	The term is also used to refer to the overall **system** that includes grievances and appeals handled at the CCN level.
Health care Effectiveness Data and Information Set (HEDIS	A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (*e.g*. CCN) performance.
Health Care Provider	A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of Louisiana (or location(s) in which the entity or person provides services),

	including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A federal law (Public Law 104-191) and its accompanying regulations enacted to, among other things, improve the portability and continuity of health insurance, combat waste, fraud, and abuse in health insurance and health care delivery, and simplify the administration of health insurance through the development of standards for the electronic exchange of health care information and protecting the security and privacy of personally identifiable health information.
Managed Care Organization (MCO)	An entity, typically risk bearing, that manages the purchase and provision of physical and/or behavioral health services under the Medicaid Program.
Medically Necessary Services	Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at

	his discretion on a case-by-case basis.
Member	An individual who is enrolled with LaCare under the Louisiana Medicaid Program and for whom LaCare has agreed to arrange the provision of covered health services under the provisions of the MA Contract.
Mental Retardation	An impairment in intellectual functioning that is lifelong and originates during the developmental period (birth to twenty-two (22) years). It results in substantial limitations in three or more of the following areas: learning, self-direction; self care; expressive and/or receptive language; mobility; capacity for independent living; and economic self-sufficiency.
National Provider Identifier (NPI)	A unique identifier for every Health Care Provider on a national level. NPIs replace Provider Identification Numbers (PINs) assigned by Medicare, Medicaid and local carriers. NPIs will replace Provider Unique Physician/practitioner Numbers (UPINs). It is not a replacement of or substitution for Tax Identification or Drug Enforcement Administration (DEA) numbers.
Network	All contracted or employed Providers with LaCare who are providing covered services to members.
network provider	A Provider who has a written Provider Agreement with and is credentialed by LaCare, and who participates in LaCare's Provider Network to serve members.
Non-Emergency Medical Transportation (NEMT)	A ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. NEMT does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.
Non-Participating Provider	A Health Care Provider, whether a person, firm, corporation, or other entity, either not participating in LaCare's Network, which provides medical services or supplies to LaCare members.
Nursing Facility	• A general, county or hospital-based nursing facility, which is

	licensed by the proper entity, enrolled in the Louisiana Medicaid Program and certified for Medicare participation.
Observation Care	Observation Care is a clinically appropriate Utilization Management designation for patient services, which include ongoing short term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or whether they can be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the Observation Care or to admit the patient as an inpatient can be made in less than 30 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient Observation services span more than 30 hours.
Out-of-Plan Services	Services that are non-plan, non-capitated and are not the responsibility of LaCare under the Louisiana CNN benefit package.
Post-Stabilization Services	Medically Necessary non-Emergency Services furnished to a member after the member is stabilized following an Emergency Medical Condition.
Primary Care Practitioner (PCP)	An individual physician or licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.
Prior Authorization	The process of determining medical necessity for specific services

	before they are rendered. .
Provider	Either (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.
Provider Agreement	Any Department approved written agreement between LaCare and a Provider to provide medical or professional services to LaCare members.
Quality Management	An ongoing, objective and systematic process of monitoring, evaluating and improving the quality, appropriateness and effectiveness of care.
Retrospective Review	A review conducted by LaCare to determine whether services were delivered as prescribed and consistent with LaCare's payment policies and procedures.
Sanction	An adverse action taken against a physician or allied health professional's participating status with LaCare for a serious deviation from, or repeated non-compliance with, LaCare's quality standards, and/or recognized treatment patterns of the organized medical community.
Short Procedure Unit (SPU)	A department within a hospital where simple procedures or surgeries are performed on an outpatient basis.
Special Needs	The circumstances for which a member will be classified as having a special need will be based on a non-categorical or generic perspective that identifies key attributes of physical, developmental, emotional or behavioral conditions, as determined by the Louisiana Medicaid Program.
Subcontract	Any contract between LaCare and an individual, business, university, governmental entity, or nonprofit organization to perform part or all of LaCare's responsibilities under the Louisiana

	Medicaid Program.
Third Party Liability (TPL)	The financial responsibility for all or part of a member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than LaCare.
Title XVIII (Medicare)	A federally-financed health insurance program administered by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 U.S.C.A. 1395 et seq., covering almost all Americans sixty-five (65) years of age and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease.
Transitional Care Home	A tertiary care center that provides medical and personal care services to children upon discharge from the hospital that require intensive medical care for an extended period of time. This transition allows for the caregiver to be trained in the care of the child, so that the child can eventually be placed in the caregiver's home.
Urgent Care	Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. (Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, suspected fracture; urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.
Utilization Management	An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

Important Forms (Appendices)

Section

1. Kid Med Periodicity
2. Louisiana Immunization Manual
3. Louisiana Immunization Schedule
4. AAP Immunization Schedule
6. Referral Form
7. Supply Request Form
8. Observation Billing Guidelines
9. Hospital Emergent Admission
10. Hysterectomy consent
11. Sterilization Consent
12. Abortion Certification
13. Newborn Manual
14. NB Pregnancy Risk Assessment
16. Stat Labs
17. Serious Reportable Events
18. Serious Screening Codes
19. Multiple Claims Project Sheet
20. Provider Change Form
21. Provider File Grievance for Member
23. Non-Par ER Services Payment Guidelines
24. Provider Quick Reference Guide
25. Member Benefits Grid